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

This Plan of Correction is the center's credible allegation of compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535031	A. BUILDING _____ B. WING _____	09/11/2014

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION - WIND RIVER	1002 FOREST DRIVE RIVERTON, WY 82501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: CAA- Care Area Assessment CDM- Certified Dietary Manager CNA- Certified Nurse Aide DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set RN- Registered Nurse VRE- Vancomycin Resistant Enterococcus MRSA- Methicillin-resistant Staphylococcus UTI- Urinary Tract Infection Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157	F157 Oct. 23, 2014 Corrective Action: Wound re-assessed and physician notified of current status of resident #15 wound, new treatment orders obtained as needed. Braden Risk Assessment reviewed for accuracy and updated and care plan updated for resident #15. Resident #4 has discharged from the facility. Identification of Others: Skin inspection of high risk residents based on current Braden score completed. Assessment of current residents on antibiotic therapy complete. Notification of physician completed as needed. Systemic Changes: Education provided by SDC/designee to LN staff regarding signs and symptoms of infection, complications and impaired wound healing, adverse response to antibiotic therapy and notification of physician. Monitoring: DNS/designee will complete random audit of applicable documentation associated with alert charting log, wound log, and 24 hour report as applicable 3 X weekly for notification of physician. Trends identified through monitoring will be brought to the center Performance Improvement Committee monthly for review by the IDT until a lesser frequency is deemed appropriate.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Executive Director 10.30.14

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.

Changes made per phone call with Joan Godwin, Esq. on 10/8/14 @ 1:57pm. POC accepted. Janice Cook, OSHC

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F 157	Continued From page 1 The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interview, the facility failed to ensure the physician was notified of a change in resident condition for 2 of 13 sample residents (#4, #15) identified as having a change in their condition. The findings were: 1. Review of the medical record showed resident #4 was admitted to the facility on 6/10/14. Review of the most recent MDS assessment dated 9/3/14 revealed the resident was cognitively intact. Review of nursing progress notes dated 8/21/14 through 9/11/14 showed the resident began taking oral antibiotic medication for a suspected UTI on 8/21/14. A nursing note on 8/23/14 revealed the resident was, "nauseous with dry heaves" and his/her antibiotic was held related to nausea. Review of a urine culture and sensitivity dated 8/23/14 identified the resident as having VRE (a bacteria that is resistant to many types of antibiotics including vancomycin). Review of a progress note entry on 8/25/14 showed s/he verbalized not feeling well since starting on	F 167	F253 Correction Action: Base board in Community Room was replaced; the corner baseboard located across from room 32 chipped/gouged area was repaired; the kick panel on the corridor doors located between rooms 28 and 29 has been replaced; the plaster on the right side of the bathroom door in Resident room 3 has been repaired; the tub room closet door has been replaced; the kick panel on the housekeeping supply closet door off the small Resident dining room has been replaced. Identification of Others: An audit of all baseboards and kick panels throughout the facility will be preformed. Any necessary repair/replacement will be completed. Systemic Changes: Maintenance Supervisor provided education to all staff to identify repair/replacement needs identified above. Monitoring: Baseboards and kick panels were placed on the monthly audits completed by the Maintenance Supervisor. Any findings will be brought to the Performance Improvement Committee monthly for review by the IDT until a lesser frequency is deemed appropriate.	10/3/14

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F 157	Continued From page 2 antibiotic therapy for the infection, negatively impacting physical therapy progression. A nursing note dated 9/1/14 revealed the resident was up to use the bathroom and complained s/he didn't feel very good. Again on 9/1/14 and 9/2/14, the resident remained in bed, taking small amounts of offered meals and refused to take antibiotics because s/he felt it was causing gastrointestinal problems. Review of the medical record revealed a hand-written note signed and dated by the resident on 9/1/14 addressing both primary physicians, in which the resident requested an IV for his/her antibiotics related to feeling, "terribly sick to my stomach". The resident addressed the importance of finishing the antibiotic but expressed that s/he had, "experienced such severe stomach trouble/pain that I had to stop the antibiotic the evening of August 31...during the night my heart was racing wildly and I have been on oxygen the past two days". Observation and interview with the resident on 9/9/14 at 4 PM showed the resident was alert and oriented and lying in bed. S/he was pale and thin. The resident complained; " I have not been able to eat very much since I started taking antibiotics for this infection in August because it hurts my stomach so bad." Review of the medical record additionally showed the physician had not been notified by nursing staff until 9/2/14 when the nurse reported the resident was, "still not feeling well" (11 days after the resident began complaining of stomach pain). RN #1 was informed of the resident's complaint of stomach pain by state survey agency staff on 9/9/14 at 5 PM. The RN's response was that the physician's office was closed; however the physician would make rounds in the facility on Thursday (2 days later). Further, interview revealed the physician did not often respond to calls and would address non-emergent items	F 157	F272 Corrective Action: CAA worksheets for residents #7, #15, #26, and #27 were reviewed and updated for accuracy based on most current MDS. Identification of Others: An audit of resident MDS Assessments completed in the last 30 days was performed. Audit of CAA worksheets for analysis was complete. Systemic Changes: Education was provided by DDCM to persons with access to completion of MDS and CAA worksheets. Monitoring: DNS/designee will audit CAA completion according to RAI schedule for accuracy and analysis. Trends identified through monitoring will be brought to the center Performance Improvement Committee monthly for review by the IDT until a lesser frequency is deemed appropriate.	10/23/14

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F 157	Continued From page 3 when making rounds in the facility. Review of a nursing note dated 9/9/14 showed the resident, "continues to decline physically...today had complaints of nausea...color is ashen and pale...MD is aware of [resident's name] physical condition". 2. Review of the medical record for resident #15 showed s/he had diagnoses to include diabetes, hyperlipidemia and hypertension. Review of the nurse's progress note dated 9/5/14 showed the resident had a pressure ulcer which measured 2 cm (centimeters) by 2 cm. The wound was initially observed on 6/19/14. The following concerns were identified: a. Review of the 6/17/14 quarterly MDS assessment showed the resident was not at risk for developing a pressure ulcer. Further, the assessment showed s/he did not have a pressure ulcer. Review of the nurse's note dated 6/20/14, 3 days following the completed MDS assessment, showed the resident complained of "sore on my rectum." The nurse examined the area and noted; "a very angry red area on tail bone approximately 3 cm x 3 cm with a 1.5 cm open area." The wound was cleaned and barrier cream applied. There was no documentation to show the physician was notified. b. The nursing note dated 6/23/14 showed there were 2 open areas located above the coccyx area, each measured 2 cm by 0.75 cm. A hydrocolloid dressing was placed over the wound. There was no indication the physician was notified. c. Review of the nurse's note dated 6/29/14 showed the wound measured 4 cm by 2 cm with a depth of 1 cm, indicating it was a Stage III pressure ulcer. The note further showed the physician would be notified, 9 days after the initial	F 157	F280 Corrective Action: Care Plans for residents #7, and #15 were updated to reflect current status and interventions. Resident #4 has discharged from the facility. Identification of Others: An audit of residents with infections was completed and care plans updated as needed. An audit of residents with current wounds was completed and care plans updated as needed. Systemic Changes: Education provided to LN by SDC/designee on updating care plans to reflect current interventions. Monitoring: DNS/Designee will complete audit of new physician orders 3xweekly to validate care plan accuracy Trends identified through monitoring will be brought to the center Performance Improvement Committee monthly for review by the IDT until a lesser frequency is deemed appropriate.	10/27/14

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F 157	Continued From page 4 observation of the wound. d. A physician order was obtained on 6/30/14 for a change in the treatment of the wound. The wound assessment on 7/1/14 showed the wound had further increased in dimensions to 5 cm by 3 cm. e. Review of the physician office visit note dated 7/3/14 showed the resident had a sacral decubitus ulcer. He described the wound as follows; "This is big and looks infected. It was deep, [His/her] chances of good wound healing are poor given [his/her] known vascular disease, and diabetes, obesity, urinary incontinence, mobility problems." At the time of the exit on 9/11/14 at 12:20 PM the corporate nurse indicated there was no further evidence the physician had been notified of the initial development of the wound before 6/30/14 when it was noted to be a Stage III pressure ulcer. As of 9/26/14 the facility failed to provide the state survey agency with any additional information regarding physician notification. Review of the policy and procedure for prevention and treatment of pressure ulcers and non-pressure related wounds last dated 2/28/14 showed the staff was to communicate with the physician and document the communication.	F 157	F281 Corrective Action: Comprehensive skin and wound assessment was complete for resident #7. Resident #4 has discharged from the facility. Identification of Others: An audit of residents with wounds was complete to verify accurate assessment in place. Corrections were made as needed. An audit of residents with peripheral IVs was complete to verify treatment orders and monitoring. Systemic Changes: Education was provided by SDC/designee to LN staff regarding assessment and documentation of wounds and policies and procedure for changing IV sites. Monitoring: DNS/designee will monitor IV administration records 3X weekly to validate treatment completion and site change as appropriate. DNS/designee will audit skin assessments 3X weekly for identification of wounds. Trends identified through monitoring will be brought to the center Performance Improvement Committee monthly for review by the IDT until a lesser frequency is deemed appropriate.	10/3/14
~~F 253~~ SS=D	~~483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES~~ The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced	~~F 253~~		

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F 253	Continued From page 5 by: Based on observation and staff interview, the facility failed to ensure resident areas were maintained in 2 of 3 areas. The findings were: Random observations on 9/10/14 showed the following items needed repairs: a. 76 inches of base board was missing in the Community Room located left of the door entering the room. b. The corner baseboard located across from room 32 in the corridor had a 2 inch by 2 inch chipped/gouged area. c. The kick panel on the corridor doors located between rooms 28 and 29 was cracked with a jagged edge pulled away from the door that measured 4 inches long and 4 inches from the floor. d. The plaster was chipped/gouged covering an area 1 inch by 5 inches and 5 inches from the floor located on the right side of the bathroom door in resident room 3. e. The tub room closet door located across from resident room 27 had a gouge that measured 1 inch by 10 inches exposing the core of the door. f. The bottom portion of the kick panel on the door of the housekeeping supply closet located across from the small resident dining room was missing. The missing portion measured 36 inches by 4 inches at its widest point. During an interview and observation of the items needing repairs with the maintenance director on 9/11/14 at 9:30 AM, he verified the repairs needed to be completed.	F 253	F282 Corrective Action: Verification of tray card for accuracy was completed on resident #26. Updates were completed as needed. Skin assessment was complete on resident #7, orders clarified and care plan updated as indicated. Identification of Others: Audit of tray cards to diet orders was complete to verify interventions in place and care plan accuracy. An audit of residents with wounds was complete to verify current assessment and appropriate treatment in place. Systemic Changes: Education was provided by SDC/designee to LN regarding documentation and assessment of wounds. Education was provided to nursing staff regarding providing meals and adaptive equipment according to physician order and care plan. Monitoring: ED/designee will perform dining observation 3X weekly to verify meals are given according to tray card. DNS/designee will review wound logs and applicable documentation for completion weekly. Trends identified through monitoring will be brought to the center Performance Improvement Committee	10/31/14
F 272	483.20(b)(1) COMPREHENSIVE	F 272		

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F 272	Continued From page 6	F 272	monthly for review by the IDT until a lesser frequency is deemed appropriate.	
38=E	ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.		F309 Corrective Action: Resident #4 has discharge from facility. Identification of Others: A baseline audit of center residents completed to identify those with pain concerns that exceed resident stated acceptable level of pain. Physician notified and orders updated as applicable. Systemic Changes: Education was provided by SDC/designee to LN staff regarding notification of physician for change in condition and assessment of pain. Monitoring: DNS/designee will audit medication records 3X weekly for pain monitoring and notification of physician. Trends identified through monitoring will be brought to the center Performance Improvement Committee monthly for review by the IDT until a lesser frequency is deemed appropriate.	10/23/14

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F 272	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure comprehensive assessments were completed in a variety of areas for 4 of 11 sample residents (#7, #15, #26, #27). The findings were: 1. Review of the 11/8/13 admission MDS assessment for resident #26 revealed the following areas triggered which required a comprehensive assessment: cognitive loss, visual function, ADL (Activities of Daily Living) function, urinary incontinence, behavioral symptoms, falls, nutritional status, pressure ulcer, and psychotropic drug use. Review of the CAA worksheets for the triggered areas revealed they were incomplete. There lacked an analysis of findings and the name and signature of the person completing the CAA was listed as "System Populated- MDS3 Import." 2. Review of the 2/12/14 admission MDS for resident #27 revealed the following areas triggered which required a comprehensive assessment: cognitive loss, communication, urinary incontinence, behavioral symptoms, falls, nutritional status, dental care, pressure ulcer, and psychotropic drug use. Review of the CAAs for the triggered areas showed they were incomplete and the name of the person completing the CAA was listed as "System Populated- MDS3 Import." 3. Review of the 9/26/13 annual MDS assessment, section V, showed resident #15 triggered for delirium, visual function, communication, ADL function, falls, nutrition and	F 272	F314 Corrective Action: Skin assessments were completed on resident #7 and #15. Physician was notified and new orders obtained as needed. Identification of Others: Skin assessments were completed on current residents. Physician notified and new orders obtained as needed. Systemic Change: Education was provided by SDC/designee to LN staff regarding staging wounds, assessments, timely interventions, and notification to physician for change in condition and lack of response to treatment. Monitoring: DNS/designee will monitor skin assessments 3X weekly for new impairment. DNS/designee will perform weekly wound rounds with LN staff. Trends identified through monitoring will be brought to the center Performance Improvement Committee monthly for review by the IDT until a lesser frequency is deemed appropriate.	10/23/14

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F 272	Continued From page 8 pain. Review of the CAA worksheet for these areas failed to show causes or contributing factors related to the identified problems. In addition, the analysis of the findings did not include any risk factors associated with the care areas. It only showed what was included in the MDS assessment. 4. Review of the 3/4/14 admission MDS assessment, section V, showed resident #7 triggered for cognitive loss, communication, ADL function, urinary incontinence, psychosocial well-being, activities, falls, nutrition, pressure ulcers and psychotropic drug use. Review of the CAA worksheet for these areas failed to show causes or contributing factors related to the identified problems. In addition, the analysis of the findings did not include any risk factors associated with the care areas. It only showed what was included in the MDS assessment. 5. During an interview on 9/10/14 at 3:20 PM the MDS coordinator stated he agreed some of the CAAs were not complete. He stated another person did some of the MDS assessments and there may have been some confusion on how to complete the CAAs.	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the	F 280	F332 Corrective Action: Resident #8 and #40 assessed and found to have no adverse effects related to medication administration. Identification of Others: An audit of medication administration records for the previous 30 days completed for current residents physician notification completed as applicable. System Change: Education and competency validation related to medication administration completed by the SDC/Designee for licensed nursing staff. Monitoring: The DNS/Designee will conduct random review of MARs/TAR 3Xweekly. Identified trends will be brought to the center Performance Improvement Committee monthly and as needed until a lesser frequency is deemed appropriate.	10/23/14

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F 280	Continued From page 9 comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure careplans were updated to reflect the individualized needs of the resident for 3 of 13 sample residents (#4, #7, #15). The findings were: 1. Review of the medical record showed resident #4 had been identified as having a UTI which was isolated and identified by laboratory culture as VRE. Review of the care plan revealed it had been updated on 8/22/14 and identified the resident as having the potential for a UTI related to the signs and symptoms of infection. Interventions included monitoring and recording urine color, odor, and maintaining universal precautions. However, the care plan had not been updated to reflect the resident's identified infection with a multi-drug antibiotic resistant infection. Review of facility policy entitled, "Multidrug-Resistant Organisms" dated 2/28/14	F 280	F360 Corrective Action: Verification of tray card for accuracy was completed on resident #26. Physician notified and care plan updated as applicable. ~~Skin assessment was complete on resident #7.~~ Identification of Others: Audit of tray cards to diet orders was complete to verify interventions in place and care plan updated as indicated. An audit of residents with wounds was complete to verify current assessment in place, physician notified and care plan updated as applicable. Systemic Changes: ~~Education was provided by SDC/designee to LN regarding documentation and assessment of wounds.~~ Education was provided to nursing staff regarding providing meals according to care plan. Monitoring: ED/designee will perform dining observation 3X weekly to verify meals are given according to tray card. ~~DNS/designee will review wound logs and applicable documentation for completion weekly.~~	10/23/14

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F 280	Continued From page 10 showed, "VRE 2. Update care plan". 2. Observation on 9/9/14 at 4:15 PM showed resident #7 had a sign posted on his/her door for contact precautions. In addition, there were gowns and gloves available for use during direct patient care. During an interview with the DON on 9/8/14 at 3:30 PM, she indicated the resident had MRSA (methicillin-resistant Staphylococcus aureus) in the wound located on his/ her coccyx. Review of the care plan showed the resident had MRSA, initiated on 7/11/14. Interventions included; "Implement isolation precautions." It did not include the type of isolation and what precautions needed to be taken while providing care to the resident. Further, it did not include the type of protective equipment needed and when it was appropriate for use. 3. Observation on 9/9/14 at 10:45 AM showed RN #1 provided wound care to resident #16 who had an open wound on his/her coccyx. Further, the resident used a wheelchair with a padded seat for locomotion and wore an incontinence pad. Review of the nurse's progress note dated 9/6/14 showed the wound was a pressure ulcer which measured 2 cm (centimeters) by 2 cm. The wound was initially observed on 6/19/14. Review of the care plan for pressure ulcers showed the staff was to encourage frequent position changes, monitor for signs and symptoms of infection and use protective skin care with incontinent care. It failed to show the use of any pressure relieving devices for the bed and wheelchair, how frequently the resident needed to change positions and that the resident had dressing changes to include frequency. 4. During an interview with the DON and	F 280	Trends identified through monitoring will be brought to the center Performance Improvement Committee monthly for review by the IDT until a lesser frequency is deemed appropriate. F369 Corrective Action: Verification of tray card for accuracy was completed on resident #26. Updates were completed as needed. ~~Skin assessment was complete on resident #7, physician notified as indicated and care plan updated.~~ Identification of Others: Audit of tray cards to diet orders was complete to verify interventions in place. ~~An audit of residents with wounds was complete to verify current assessment in place, care plan updated, and physician notified as indicated.~~ Systemic Changes: ~~Education was provided by SDC/designee to LN regarding documentation and assessment of wounds.~~ Education was provided to nursing staff regarding providing meals according to care plan, physician orders, and adaptive equipment. Monitoring: ED/designee will perform dining observation 3X weekly to verify meals are given according to tray card. ~~DNS/designee will review wound logs and applicable documentation for completion weekly.~~	10/23/14

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F 280	Continued From page 11 corporate nurse on 9/11/14 at 10:30 AM, they acknowledged the care plans needed to be updated.	F 280	Trends identified through monitoring will be brought to the center Performance Improvement Committee monthly for review by the IDT until a lesser frequency is deemed appropriate.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure a comprehensive wound assessment was completed for 1 of 4 sample residents (#7) with wounds. Further, the facility failed to change an IV (intravenous) site for 1 of 1 sample residents (#4) with an IV. The findings were: 1. Review of the medical record for resident #7 showed s/he had diagnoses to include Steven-Johnson syndrome (systemic skin disease). Review of the 4/16/14 nurse skin check document showed the resident had multiple scabbed areas located on the left and right lower extremities. Further review showed from 4/23/14 through 5/21/14 the resident had no skin conditions. On 5/28/14 it was noted there was an open area located on the left buttock. On 6/4/14 again it was noted there were no skin conditions. Continued review of the notes showed on 7/8/14 there were no skin issues, and on 7/15/14 the resident had "multiple skin issues." It did not describe the issues, the location or severity of the condition of the skin. On 7/23/14 it showed: "Continues with sores to legs and buttocks." Review of the 5/22/14 skin clinic assessment	F 281	F441 Corrective Action: Resident #7 was re-assessed for current infection status. Interventions were placed based on results. Resident #15 was reassessed for current infection status. Interventions were placed based on results. Resident #4 has discharged from the facility. Identification of Others: All residents have the potential to be affected. Current residents reviewed to validate appropriate precautions in place and careplan updated if indicated. Systemic Change: DDCO/designee will provide SDC regarding isolation procedures and precautions. Education was provided by SDC/designee to staff regarding handwashing, dressing changes, and isolation precautions.	10/23/14

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F 281	Continued From page 12 note showed the resident had "intact bullous erosions on the legs, arms, back [with] some intact blisters." Further, the note showed the skin condition was not controlled and the resident was started on the medication prednisone (for severe inflammation). The 5/21/14 nurse skin check document had shown there were no skin issues. The skin clinic note dated 7/10/14 showed the resident had continuous new blisters to the lower extremities with pain and itching. Further, it showed the condition was worsening. The nurse skin assessment documentation between 7/1/14 and 7/15/14 did not accurately describe the location, severity or extent of the lesions. Further, there were inconsistencies in the documented observations. Observations on 9/9/14 at 4:15 PM and 9/11/14 at 12:10 PM showed the resident had lesions located on his/her lower extremities with an open wound on the left knee. Further, there were closed lesions located on the resident's coccyx and the surrounding skin. During an interview with the DON and corporate nurse on 9/11/14 at 10:30 AM, they acknowledged there were inconsistencies in the documentation of the resident's wounds. According to recommendations by the WOCN (Wound Ostomy and Continence Nurse Society) nurses' association publication dated 2010, "Assessment and documentation of wound status which includes comprehensive clinical data demonstrating evidence of progress in healing or failure to heal. Parameters for comprehensive wound assessment include: dimensions and depth; presence, location and depth of any sinus tracts or undermining areas; status of the wound bed (granulating or epithelializing vs. clean but not granulating vs. avascular); volume, color, and odor of exudate; evidence of infection in surrounding tissues (erythema, induration,	F 281	Monitoring: DNS/designee will monitor residents being treated for infections weekly for appropriate precautions in place. DNS/designee will monitor random wound dressing change weekly for proper infection control practices. DNS/designee will perform medication pass observation 3X weekly. Trends identified through monitoring will be brought to the center Performance Improvement Committee monthly for review by the IDT until a lesser frequency is deemed appropriate. F465 Corrective Action: The current kitchen floor will be replaced. Identification of others: An Audit was completed of other floors in the facility and floors were found to be within parameters of the regulation. Systemic Change: Education will be provided by the Maintenance Supervisor for all staff to be aware of the condition of the floors. Monitoring: Maintenance Supervisor will add the condition of facility floors to the maintenance monthly audits. Any findings will be brought to the Performance Improvement Committee monthly for review by the IDT until a lesser frequency is deemed appropriate.	10/23/14

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F 281	Continued From page 13 crepitance); and status of wound edges (closed and nonproliferative vs. open and proliferative). Such data, when sequentially recorded over time, can be used to objectively track the progress of wound healing. The use of wound descriptors to accurately convey the true state of the wound in addition to documenting the stage of the wound." 2. Review of the medical record showed resident #4 had an IV catheter placed in the left forearm on 9/2/14. Observation on 9/8/14 at 3:45 PM revealed the resident had an intermittent IV catheter located in the left forearm. The dressing was dated 9/2/14. Observation again on 9/9/14 at 8:30 AM revealed the resident continued to have the same intermittent IV and dressing in the left forearm that was dated 9/2/14. Review of the medical record further showed a physician's order dated 9/3/14 to change the IV catheter every 3 days. Interview with the DON and RN #1 on 9/9/14 verified the resident's IV catheter had been inserted on 9/2/14. The RN recalled he thought IVs were supposed to be changed every 3 days. However, the DON reported that IV sites were supposed to be changed once a week unless there were complications with the site or IV therapy. Review of the facility's policy and procedure entitled, "Peripheral Catheter Insertion" and dated July 1, 2012 showed, "7. Peripheral catheter sites are rotated: every 96 hours [4 days]...In situations where peripheral venous access is limited, the decision to leave the catheter dwelling beyond 96 hours must depend on assessment of the venous site...and must be documented in the resident's medical record. A physician's order is necessary to extend dwell time beyond 96 hours".	F 281	F468 Corrective Action: The corridor handrails between Resident rooms 32 and 33 were repaired: The handrail between Resident room 11 and the door labeled for housekeeping was repaired. Identification of Others: An audit of all handrails in the facility was completed by Maintenance Supervisor and/or designee to identify any other handrails needing repair. Systemic Changes: The Maintenance Supervisor will educate all staff concerning the identification of any handrail requiring repairs. Monitoring: The Maintenance Supervisor will place handrail safety on the monthly maintenance audits. Any findings will be brought to the Performance Improvement Committee monthly for review by the IDT until a lesser frequency is deemed appropriate.	10/23/14

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F 282	Continued From page 14	F 282		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure care was provided in accordance with the written plan of care for 2 of 13 sample residents (#7, #26). The findings were: 1. Review of the current care plan for resident #26, last revised 9/3/14, showed a plateguard for meals was supposed to be provided. In addition, the care plan instructed staff to honor his/her dislikes by not offering hot cereal and scrambled eggs. Staff were instructed to offer food items such as fried eggs and cold cereal. Observation on 9/9/14 at 7:35 AM revealed CNA #1 gave the resident's tray to another resident (#27) by mistake. That tray had a fried egg, yogurt and cold cereal. The tray also had a plateguard. CNA #2 realized the mistake at 7:46 AM, but instead of calling the kitchen to get another tray for the resident, she gave the resident the tray that was supposed to be for resident #27. That tray had an omelet and hot cereal and did not have a plateguard. At 7:55 AM the resident told CNA #2 that s/he didn't like hot cereal and the CNA replied "you don't have to eat it." At 8:20 AM, the resident pushed his/her chair away from the table. S/he had eaten only bites of the omelet and none of the hot cereal. During an interview on	F 282		

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F 282	Continued From page 15 9/10/14 at 2:25 AM the CDM confirmed the resident should have received a fried egg, yogurt and cold cereal for breakfast, and was supposed to use a plateguard. She further stated if the CNA had called the kitchen after the tray mix-up, they could have sent another tray for the resident quickly. 2. Review of the care plan for resident #7 related to pressure ulcers showed interventions included a weekly pressure ulcer condition report was to be instituted on 5/26/14. The size and staging of the wound was to be included. Review of the weekly pressure ulcer report showed the measurements and staging was completed on 6/28/14, 6/4/14, 6/11/14 and then not until 7/1/14 (20 days later). The 7/1/14 pressure ulcer report showed the ulcer measured 2.5 cm by 1 cm and remained a stage II pressure ulcer. Further review showed no additional documentation was completed for the pressure ulcer to include if it had resolved. Interview with the DON and corporate on 9/11/14 at 10:30 AM revealed the pressure ulcer needed to be monitored weekly. Further, the nursing staff needed to follow the care plan.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff and resident interviews, the facility failed to ensure pain was addressed for 1 of 8 residents (#4) identified as having pain. The findings were: Review of the medical record showed resident #4 was admitted to the facility on 8/10/14. Review of the most recent MDS assessment dated 9/3/14 revealed the resident was cognitively intact. Review of nursing progress notes dated 8/21/14 through 9/11/14 showed the resident began taking oral antibiotic medication for a suspected urinary tract infection on 8/21/14. A nursing note on 8/23/14 revealed the resident was, "nauseous with dry heaves", and his/her antibiotic was held related to nausea. Review of a urine culture and sensitivity dated 8/23/14 identified the resident as having vancomycin-resistant enterococcus (VRE a bacteria that is resistant to many types of antibiotics including vancomycin). Review of a progress note entry on 8/26/14 showed s/he verbalized not feeling well since starting on antibiotic therapy for the infection, negatively impacting physical therapy progression. A nursing note dated 9/1/14 revealed the resident was up to use the bathroom, and complained s/he didn't feel very good. Again on 9/1/14 and 9/2/14, the resident remained in bed, taking small amounts of offered meals, and refused to take antibiotics because s/he felt it was causing gastrointestinal problems. Review of the medical record revealed a note written and signed by the resident and dated 9/1/14 addressing both primary physicians, in which the resident requested an IV for his/her antibiotics related to feeling, "terribly sick to my stomach". The resident addressed the importance of finishing the antibiotic but	F 309		

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F 309	Continued From page 17 expressed that s/he had, "experienced such severe stomach trouble/pain that I had to stop the antibiotic the evening of August 31...during the night my heart was racing wildly and I have been on oxygen the past two days." The following concerns were identified: a. Observation and interview with the resident on 9/9/14 at 4 PM showed the resident was alert and oriented and lying in bed. S/he was pale and thin. The resident complained; "I have not been able to eat very much since I started taking antibiotics for this infection in August because it hurts my stomach so bad." Review of the medical record additionally showed no documentation the physician had been notified of the resident's recurrent complaints of stomach pain. b. Review of the medical record showed a physician's order dated 9/10/14 for Maalox Plus Extra Strength 30 ml (milliliters) 4 times daily as needed for acid stomach. Review of the August and September 2014 MARs (Medication Administration Record) revealed the resident had not been given any doses of the Maalox. c. RN #1 was informed of the resident's complaint of stomach pain by state survey agency staff on 9/9/14 at 5 PM. The RN responded the physician's office was closed, however the physician would make rounds in the facility on Thursday (2 days later). Further, interview revealed the physician did not often respond to calls and would address non-emergent items when making rounds in the facility. d. During an interview with the administrator on 9/11/14 at 11:30 AM she confirmed nursing staff were supposed to notify the facility's medical director if they were unable to reach the resident's primary physician.	F 309		
F 314	483.25(c) TREATMENT/SVCS TO	F 314		

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F 314 SS=G	Continued From page 18 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 medical record review, observation and staff interview, the facility failed to ensure assessments and interventions were timely and consistent to prevent worsening of pressure ulcers for 2 of 3 sample residents (#7, #16) identified as having pressure ulcers. The lack of timely assessments and intervention resulted in harm for resident #15. The findings were: 1. Review of the medical record for resident #15 showed s/he had diagnoses to include diabetes, hyperlipidemia and hypertension. Observation on 9/9/14 at 10:45 AM showed the resident had an open wound on his/her coccyx. Further, the resident used a wheelchair with a padded seat for locomotion and wore an incontinence pad. The following concerns were identified: a. Review of the 6/17/14 quarterly MDS assessment showed the resident was not at risk for developing a pressure ulcer and did not have a pressure ulcer. The assessment showed the resident did not walk and used a wheelchair for mobility. Review of the nurse's note dated 6/20/14, 3 days following the completed MDS	F 314		

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F 314	Continued From page 19 assessment, showed the resident complained of a "sore on my rectum." The nurse examined the area and noted: "a very angry red area on tail bone approximately 3 cm x 3 cm with a 1.5 cm open area." The wound was cleaned and barrier cream applied. There was no documentation to show the physician was notified. b. The nursing note dated 6/23/14 showed there were 2 open areas located above the coccyx area that each measured 2 cm by 0.75 cm. A hydrocolloid dressing was placed over the wound. There was no indication the physician was notified. c. Review of the nurse's note dated 6/29/14 showed the wound measured 4 cm by 2 cm with a depth of 1 cm, indicating it was a Stage III pressure ulcer. The note further showed the physician would be notified (9 days after the initial observation of the wound). d. A physician order was obtained on 6/30/14 for a change in the treatment of the wound. The wound assessment on 7/1/14 showed the wound had further increased in dimensions to 5 cm by 3 cm. e. Review of the physician office visit note dated 7/3/14 showed the resident had a sacral decubitus ulcer. He described the wound as follows: "This is big and looks infected. It was deep. [His/her] chances of good wound healing are poor given [his/her] known vascular disease, and diabetes, obesity, urinary incontinence, mobility problems." Review of the policy and procedure for prevention and treatment of pressure ulcers and non-pressure related wounds last dated 2/28/14 showed: "Pressure ulcer and other wound and skin related interventions are created in collaboration with the interdisciplinary team and	F 314		

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(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 314	Continued From page 20 implemented in order to identify, prevent or reduce the risk of acquiring pressure and/or non-pressure related wounds or skin issues." Further, the policy showed the staff was to communicate with the physician and document the communication. At the time of the exit on 9/11/14 at 12:20 PM the corporate nurse indicated there was no further evidence the physician had been notified of the initial development of the pressure ulcer before 6/30/14 when the wound was noted to be a Stage III ulcer. As of 9/25/14 the facility failed to provide any additional information to the state survey agency to demonstrate the pressure ulcer was unavoidable. 2. Review of the medical record for resident #7 showed s/he had diagnoses to include cerebral palsy and muscle weakness. Review of the weekly pressure ulcer report dated 5/28/14 showed the resident developed a new Stage II pressure ulcer that measured 2.5 cm by 1 cm. Further, the documentation failed to show the physician was notified of the new pressure ulcer. Additional measurements and staging was completed on 6/4/14, 6/11/14 and then not until 7/1/14 (20 days later). At that time, the documentation showed the ulcer measured 2.5 cm-by-1-cm-and-remained-a-stage-II-pressure ulcer. Further review showed no additional documentation had been completed for the pressure ulcer to show wound progress or regression. Review of the care plan related to pressure ulcers showed interventions included a weekly pressure ulcer condition report. The size and staging of the wound were to be included. Interview with the DON and corporate nurse on 9/11/14 at 10:30 AM revealed the pressure ulcer	F 314		

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	535031	A. BUILDING _____ B. WING _____	09/11/2014

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F 314	Continued From page 21 needed to be monitored weekly.	F 314		
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. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and staff interview, the facility failed to maintain a medication rate under 6% (percent). Two medication errors were observed out of 25 opportunities for errors, which resulted in an error rate of 8%. The findings were: 1. Observation on 9/9/14 at 5 PM showed RN #1 drew up 7 units of Novolog insulin for resident #8. In addition, the resident had a blood sugar of 219 and was to receive an additional 5 units, as ordered by the physician, for a total of 12 units of insulin. The nurse had placed the insulin in the medication cart after preparing the 7 units. State survey agency staff pointed out he needed an additional 5 units for the elevated blood glucose. He then drew up the additional insulin. 2. Observation on 9/10/14 at 9:20 AM showed LPN #1 prepared acetaminophen 500 milligrams to be given to resident #40. Review of the physician orders dated 9/7/14 showed the resident was to receive 1000 mg. During an interview with the nurse on 9/10/14 at 10:35 AM, she verified she needed to give 1000 mg of the medication.	F 332		
F 360	483.35 PROVIDED DIET MEETS NEEDS OF	F 360		

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F 360 SS=D	Continued From page 22 EACH RESIDENT The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, review of dietary documentation and staff interview, the facility failed to meet the individualized dietary needs for 1 of 13 sample residents (#26) during 1 of 2 meals observed. The findings were; Review of the dietary order slip for resident #26 revealed the resident disliked scrambled eggs and hot cereal. The slip indicated the resident should receive cold cereal, yogurt, and a fried egg each morning for breakfast. Observation on 9/9/14 at 7:35 AM revealed CNA #1 gave the resident's tray to another resident (#27) by mistake. That tray had a fried egg, yogurt and cold cereal. CNA #2 realized the mistake at 7:46 AM, but instead of calling the kitchen to get another tray for the resident, she gave the resident the tray that was supposed to be for resident #27. That tray had an omelet and hot cereal. At 7:55 AM the resident told CNA #2 that s/he didn't like hot cereal, and the CNA replied "you don't have to eat it." At 8:20 AM, the resident pushed his/her chair away from the table. S/he had eaten only bites of the omelet and none of the hot cereal. During an interview on 9/10/14 at 2:25 AM the CDM confirmed the resident should have received a fried egg, yogurt and cold cereal for breakfast. She further stated if the CNA had	F 360		

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F 360	Continued From page 23 called the kitchen after the tray mix-up, they could have sent another tray for the resident quickly.	F 360		
F 389 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of dietary documentation, the facility failed to provide adaptive equipment for 1 of 3 sample residents (#26) who required it during 1 of 2 meals observed. The findings were: Review of an order dated 8/14/14 for resident #26 showed "RD [registered dietitian] recommends plateguard at meals." Review of the dietary order slip showed the kitchen was supposed to provide a plateguard for the resident. Observation on 9/9/14 at 7:35 AM revealed CNA #1 gave the resident's tray to another resident (#27) by mistake. That tray had a plateguard. CNA #2 realized the mistake at 7:45 AM, but instead of calling the kitchen to get another tray for the resident, she gave the resident the tray that was supposed to be for resident #27. That tray did not have a plateguard. During an interview on 9/10/14 at 2:25 AM the CDM confirmed the resident was supposed to use a plateguard for meals.	F 389		
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	F 441		

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F 441	Continued From page 24 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, resident and staff interviews and review of	F 441		

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F 441	Continued From page 28 policies and procedures, the facility failed to ensure infection control practices were maintained during 4 random observations. The findings were: 1. Review of the medical record showed resident #4 had been identified as having a UTI which was isolated and identified by laboratory culture as VRE on 8/29/14. Review of the care plan revealed it had been updated on 8/22/14 and identified the resident as having the potential for a urinary tract infection related to the signs and symptoms of infection. Interventions included monitoring and recording urine color, odor and maintaining universal precautions. However, the care plan had not been updated to reflect the resident's identified infection with a multi-drug antibiotic resistant infection. The following concerns were identified: a. Periodic observations from 9/8/14 through 9/11/14 showed the resident did not have a private room and contact precautions were not observed by staff. Observation on 9/9/14 at 8:30 AM revealed housekeeper #1 did not don a gown prior to entering the resident's room and cleaning the resident's toilet. Interview with the housekeeper at the time of the observation showed she cleaned the resident's room the same as other resident rooms. The housekeeper said she had cleaned the toilet everyday because the resident had diarrhea and "the toilet was a mess." Interview further revealed if a resident was placed on contact precautions the room was cleaned differently. The housekeeper was not aware the resident had an infection. b. Observation on 9/9/14 at 11:05 AM showed the resident was assisted to the bathroom and back to bed by staff. Observation of the resident's toilet showed drops of urine on the seat and the	F 441		

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F 441	Continued From page 26 floor beside the toilet. Interview with the resident at the time of the observation revealed s/he was weak and had required the assistance of staff to get to the bathroom over the past couple of weeks. Interview further revealed the resident had often dribbled urine onto the seat and floor. c. Interview with the infection control nurse on 9/9/14 at 12:05 PM verified the resident had not been placed on contact precautions when the VRE was identified because s/he was continent of urine. d. Review of facility policy entitled; "Multidrug-Resistant Organisms" dated 2/28/14, showed "Patients Actively Infected with VRE 3. wear a clean, non-sterile gown when entering the room of a VRE infected patient if 4. substantial contact with the patient or environment surfaces in the patient's room is anticipated or 5. the patient is incontinent or has diarrhea...6. disinfect any visible fecal contamination...". In addition the policy included, "Environmental Cleaning/Disinfection 1. implement an environmental cleaning and disinfection strategy b. use an environmental protection agency registered hypochlorite-based disinfectant for environmental surface disinfection...". According to CDC guidance entitled, "Management of Multidrug-Resistant Organisms In Healthcare Setting, 2006" recommendations included placing patient's on "contact precautions...donning gown and gloves upon entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination such as VRE...". 2. Observation on 9/9/14 at 4:15 PM showed RN #1 changed the dressing of resident #7. The RN	F 441		

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F 441	Continued From page 27 donned an isolation gown and gloves upon entering the room due to having a wound infected with MRSA. He placed the topical medication and wound cleanser directly on the bedside tray used for the wound treatment. After the nurse completed the dressing change he brought the medication and wound cleanser out of the room and placed the cleanser in the treatment cart and the topical ointment was placed in the medication cart. During an interview with the nurse on 9/11/14 at 11:15 AM, he acknowledged the cleanser and medication should not have been placed in the carts. 3. Observation on 9/9/14 at 10:45 AM showed RN #1 completed wound care for resident #15. The RN donned a pair of gloves and removed the old dressing. He cleansed the wound and removed his gloves. The nurse then donned a second pair of gloves and continued to apply the topical medication and place the dressing. He did not wash his hands after removing the soiled gloves. During an interview with the nurse on 9/11/14 at 11:15 AM, he acknowledged his hands needed to be cleansed prior to donning the second pair of gloves. 4. Observation on 9/9/14 at 7:45 AM showed LPN #2 had a gloved left hand that was worn during the medication pass. The nurse cleansed his gloved hand and bare hand with sanitizer between residents. He did not remove the glove after each medication pass. 5. Review of the policy and procedure for hand hygiene/handwashing dated 8/31/11 showed hand hygiene is to be performed: "After removal of medical/surgical gloves or utility gloves..." Further, the policy showed; "Remove gloves after	F 441		

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F 441	Continued From page 28 caring for a patient/patient. Do not wear the same pair of gloves for the care of more than one patient/patient, and do not wash gloves between uses with different patients/patients."	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the floors were well maintained and sanitary in 1 of 1 kitchens. The findings were: Observation of the kitchen during the initial tour on 9/8/14 at 3:40 PM and periodically throughout the survey revealed the kitchen floor was in need of repair. There was a large area of floor missing near the dish machine, approximately 3 feet long by 6 inches wide, exposing the black under layer of the floor. In addition, the rest of the kitchen floor had more than 50 scrapes, cuts, and gouges in the surface, exposing the black under layer of the floor. During an interview on 9/10/14 at 2:25 PM the CDM stated the missing floor by the dish machine had been like that for a couple of years. On 9/11/14 at 9:45 AM the administrator stated replacing the kitchen floor had been discussed, but no definite plans had been made.	F 465		
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS	F 468		

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F 468	Continued From page 29 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 ensure the handrails were securely attached to the wall in two locations. The findings were: Random observations on 9/10/14 revealed corridor handrails were loose and broke at the seam where the boards joined in the following locations: a. Between resident rooms 32 and 33 where the boards were seamed together. b. Between resident room 11 and the door labeled for housekeeping. During an interview with the maintenance director on 9/11/14 at 9:40 AM, he acknowledged the handrails were loose at the seams and were not securely fastened to the wall. Further, he confirmed they needed to be repaired.	F 468		