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

PRINTED: 12/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING _____ B. WING _____	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN HEALTHCARE COMMUNITY	2009 LARAMIE STREET TORRINGTON, WY 82240

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: ADL - Activities of Daily Living BIMS - Brief Interview for Mental Status CAA - Care Area Assessment CNA - Certified Nursing Aide DON - Director of Nursing LPN - Licensed Practical Nurse MDS - Minimum Data Set PRN - Pro re nata (as needed) RD - Registered Dietitian ROM - Range of Motion RN - Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	RECEIVED WY Dept of Health JAN 07 2015 Healthcare Licensing and Surveys	
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse,	F 225	**F225 Investigate/Report Allegations/Individuals** 1/16/2015 **Corrective Actions:** The State Nurse Aide Registry was checked for CNA's #1, #2, #3, #4, and #5, on 12/4/2014. **Others Potentially Affected:** Any CNA hired since 08/01/2014 have the potential to not have been cleared through the State Nurse Aide Registry, thus potentially affecting all residents that reside within the facility.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: C. Kuntz - BNS | TITLE: Director of Nursing | (X6) DATE: 1-7-15

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.

1/7 15 @ 2:25 The POC accepted between Connie Lyons, DON and Tony Medina, Health Surveyor with agreed date of 1/16/15 for all three tags. 1/7 HS

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F 225	Continued From page 1 including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on employee file review, review of the state CNA abuse log, and staff interview, the facility failed to ensure the state nurse aide registry was checked prior to employment for 5 of 5 CNAs (#1, #2, #3, #4, #5). The findings were: Review of the employee files for CNAs #1, #2, #3, #4 and #5 showed there was no documentation to show the state nurse aide registry had been checked to verify these CNAs were listed and without abuse findings. Interview with the DON on 12/3/14 at 3:50 PM revealed she was not aware of the registry, and it had not been checked for these CNAs. Review of the state CNA abuse registry showed CNAs #1, #3, #4 and #5 had not	F 225	**Systemic Changes:** • Hiring Managers were trained on checking the State Nurse Aide Registry for all newly hired CNA's on 12/03/2014. • An audit was completed on all CNA's hired since 08/01/2014, to determine any other new hire that had not been cleared through the State Nurse Aide Registry. • All CNA's hired since 08/01/2014 have been run through the State Nurse Aide Registry. • The process of checking all new hired CNA's through the State Nurse Aide Registry has been added to the hiring practice. **Monitoring:** The Business Office Manager/designee will complete an audit on new hire files to ensure compliance with hiring practice of checking new CNA's through the State Nurse Aide Registry: weekly x 4 weeks, monthly x 3 months, and random thereafter.	

1/21/15

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F 225	Continued From page 2 been registered and therefore there was nothing in the registry related to these CNAs. The non-registered CNAs had the following dates of hire: a. CNA #1 was hired on 8/6/14 b. CNA #3 was hired on 10/6/14 c. CNA #4 was hired on 11/6/14 d. CNA #5 was hired on 11/21/14	F 225	**QA:** The Business Office Manager will report audit findings to the Quality Assurance Committee monthly for further analysis and recommendations. The Quality Assurance Committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the dignity of 1 of 3 sample residents (#7) in the secure unit. The findings were: Observation on 12/2/14 from 8:15 AM to 9:05 AM showed resident #7 was seated in a wheelchair in the dining room eating breakfast. The resident was wearing a zip-front sweatshirt, which was completely unzipped and the resident's bare breasts were exposed. At that time, dietary aide #1, who was walking by, stopped briefly to look at the resident, then continued to the kitchen without notifying nursing staff or offering assistance to protect the resident's dignity. At 8:18 AM, RN #1 gave the resident a glass of fluid, but failed to acknowledge the resident's need to be covered. At 8:22 AM, while the resident remained at the table with the top still open, dietary aide #1	F 241	**F241 Dignity and Respect of Individuality** 1/10/2015 **Corrective Actions:** Resident #7's zip-front sweatshirt was zipped up by RN#1, after asking the resident if she could zip up her sweatshirt; on 12/02/2014 @ 0905. **Others Potentially Affected:** No other residents were identified as having been affected by this practice. **Systemic Changes:** • All Staff will be educated on providing Dignity and Respect to the residents, by ~~1/28/2015~~. 1/16/15 • All staff will be educated on reporting inappropriate resident attire to the licensed nurse by ~~1/28/2015~~. 1/16/15 m	

1/7/15 m

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F 241	Continued From page 3 removed the resident's breakfast plate, but did not notify nursing staff of the resident's need for assistance. At 8:34 AM, dietary aide #1 gave the resident a lidded container of coffee. At 9:05 AM, the resident left the dining room, and wheeled his/her wheelchair through the milieu, at which time RN #1 asked the resident if she could zip up the clothing. Interview with the unit manager on 12/2/14 at 12:40 PM confirmed that all facility staff should either assist a partially clothed resident or notify nursing should a resident need help.	F 241	**Monitoring:** The Unit Manager/designee will perform a walking audit each morning to identify any resident who may be inappropriately attired. **QA:** Unit Manager(s) will report any resident inappropriate clothing trend to the monthly QA Committee. The Quality Assurance Committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful.	
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 by: Based on observation and staff interview, the facility failed to ensure soiled chairs were cleaned in 2 of 5 resident areas. The findings were: 1. Periodic observations on 12/3/14 of the resident common area located on the 200 hallway showed there were upholstered chairs available for resident use. The following concerns were identified: a. The brown rocking chair sitting outside resident room 207 was soiled with 3 to 4 unidentified white spots on the seat of the chair. b. The blue/green recliner located outside resident room 206 was soiled with white streaks on the seat of the chair.	F 253	**F253 Housekeeping and Maintenance Services** **Corrective Actions:** The identified upholstered chairs in the 200 and 400 hallways (outside of rooms 207, 206 and 407) have been shampooed to remove any soiled areas. **Others Potentially Affected:** A cleanliness audit was performed by the Housekeeping Director to identify any other upholstered chairs that need cleaned. No other residents were identified as having been affected by this practice.	1/10/2015

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F 253	Continued From page 4 2. The blue recliner located outside resident room 407 appeared to be soiled with brown discoloration on the seat and footrest of the chair. 3. During an interview with housekeeper #1 on 12/4/14 at 10 AM, she revealed the upholstered chairs on each unit were cleaned approximately every 6 months. Further, the chairs on the 200 hallway had been cleaned in June 2014 and chairs on the 400 hallway were cleaned in May 2014. In addition, she acknowledged the chairs needed to be cleaned or discarded.	F 253	**Systemic Changes:** • A cleaning schedule for upholstered chairs has been developed, to routinely clean chairs in common resident areas. • The Housekeeping staff will be educated on the cleaning schedule for upholstered chairs, and the necessity to report any soiled surface identified throughout routine cleaning by, ~~1/28/2015~~. 1/18/15. BJ	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	**Monitoring:** The Housekeeping Director/designee will perform an audit of Upholstered Chair Cleanliness on a weekly basis x 4 weeks, then monthly x 3 months, and then random thereafter. **QA:** The Housekeeping Director will report audit reports to the Quality Assurance Committee on a monthly basis for further analysis and recommendations. The Quality Assurance Committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful.	

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F 279	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop a comprehensive plan of care for 2 of 13 sample residents (#4, #71). The findings were: 1. Review of the resident's 2/21/14 significant change MDS assessment for resident #4 revealed the resident triggered for further assessment in the area of Psychotropic Drug Use. Review of the 2/26/14 CAA summary for psychotropic medication use revealed the facility's decision to care plan for this issue, however, review of the care plan showed no care plan for psychotropic drug use. Interview with the MDS coordinator on 12/4/14 at 11:40 AM confirmed there was no care plan for psychotropic drug use. 2. Review of the annual MDS assessment dated 4/26/14 showed resident #71 triggered for further assessment of areas including Urinary Incontinence and Indwelling Catheter, Psychotropic Drug Use, and Pain. Review of the CAAs revealed the facility decision to care plan for each of those areas, however, review of the resident's care plan showed no care plans for these areas. Interview with the MDS coordinator on 12/4/14 at 11:40 AM confirmed there were no care plans for these areas.	F 279	**F279 Develop Comprehensive Care Plans** **Corrective Actions:** A comprehensive care plan for resident #4 and resident #71 were developed. • Resident #4's care plan was reviewed by the Interdisciplinary Team and updated as indicated to reflect current resident status, including Psychotropic medications. • Resident #71's care plan was reviewed by the Interdisciplinary Team and updated as indicated to reflect current resident status, including Urinary Incontinence, Indwelling Catheters, Psychotropic Drug Use, and Pain. **Others Potentially Affected:** No other residents were identified as having been affected by this practice. **Systemic Changes:** • An audit of care plans will be completed by the MDS Nurse(s)/designee on residents triggering on the 2014 Annual MDS assessments for: Psychotropic Drug Use, Pain, or Urinary Incontinence/Indwelling Catheters. • The Licensed Nurses will be educated on developing resident centered Comprehensive Care Plans by ~~01/28/2015~~ 1/18/15	1/18/2015
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	F 280		

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F 280	Continued From page 6 changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview the facility failed to update the care plan to reflect current needs for 1 of 13 sample residents (#4). The findings were: 1. Review of nursing notes showed documentation of resident #4 touching other residents or running into other residents with his/her wheelchair were made on 16 days in October, 2014, and 21 days in November, 2014. Review of the 11/16/14 quarterly MDS assessment showed the resident exhibited physical behavioral symptoms directed toward others on a daily basis. Review of the resident's care plan for behavior problems, updated on 9/3/14, showed the resident was "becoming increasingly agitated lately and is very difficult to redirect...[S/he] is increasingly agitated at meal times and is upsetting other residents by bumping	F 280	**Monitoring:** The Interdisciplinary Team will audit care plans for comprehensive resident centered status with the MDS schedule on an ongoing basis. Identified concerns will be developed and updated as indicated. **QA:** MDS Nurse(s) will report audit data to the Quality Assurance Committee quarterly. The Quality Assurance Committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful. **F280 Right to Participate Planning Care** **Corrective Actions:** Resident #4's care plan has been reviewed by the Interdisciplinary Team and updated as indicated to reflect current resident needs, behaviors affecting others, and meaningful interventions. **Others Potentially Affected:** Resident's residing on the Secured Unit have the potential to be affected by this practice.	1/10/2015

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F 280	Continued From page 7 into them with [his/her] wheelchair..." The following concerns were identified: a. Review of nursing notes showed the resident had drinks thrown on him/her on 10/17/14 and 11/14/14, and was hit on the head by another resident on 11/23/14. b. Observation on 12/2/14 beginning at 8:15 AM showed the resident reached out to grab and shake another resident's shoulder several times. This other resident was visibly agitated when this happened and started to throw his/her drink. Staff did not intervene or move either resident. c. Further review of the care plan for behavior problems showed approaches, most recently updated 11/24/14, included reporting pain indicators, and offering conversation or something to eat or drink when the resident began to wander excessively. No meaningful approaches were developed, with regard to the resident's behaviors of touching residents and bumping into them with his/her wheelchair, to maintain the resident's safety and the rights of other residents to be free of unwanted touching. d. Interview with unit manager #1 on 12/4/14 at 8:35 AM revealed residents sat anywhere they chose for meals, even if it was next to a resident who would be agitated by unwanted touching. e. Interview with the social worker on 12/4/14 at 11:40 AM revealed he had not been included in discussions of behavioral interventions for this resident. e. Interview with the MDS coordinator on 12/4/14 at 11:40 AM confirmed the resident's care plan had not been updated with approaches specific to the resident's behaviors of touching other residents and bumping into them with his/her wheelchair.	F 280	**Systemic Changes:** • The DNS/designee will educate the Nursing Staff on resident centered care, root cause analysis, behavior monitoring, separating residents for safety, and non-pharmacological interventions, and updating care plans. • The Unit Manager/designee will audit resident behaviors on a daily basis during walking rounds. • The Licensed Nurse will update care plans as needed. • The Unit Manager/designee will communicate resident behaviors to the Social Service Director and Director of Nursing, when identified. **Monitoring:** The Social Service Director will audit care plans of any resident exhibiting behaviors, to ensure that meaningful interventions are being initiated and updated. **QA:** The Social Service Director will report audit data to the Quality Assurance Committee quarterly. The Quality Assurance Committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful.	
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		

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F 282 SS=D	Continued From page 8 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 medical record review and staff interview, the facility failed to ensure care was provided in accordance with the written plans of care for 3 of 19 sample residents (#57, #68, #72). The findings were: 1. Review of the 1/23/14 annual MDS assessment showed resident #57 had bilateral ROM limitations of the lower extremities. There were also ROM limitations on one side of the upper extremities. The 8/1/14 care plan approach related to the limited ROM showed the resident was to receive a "level one" restorative program that included ambulation. In addition, an older approach dated 4/19/13 showed passive ROM to upper extremities and ambulate with assistance of one 2-3 times a week. Review of the medical record failed to show evidence of participation in restorative services. 2. Review of the 10/23/14 annual MDS assessment showed resident #72 had bilateral ROM limitations for both upper and lower extremities. The 1/28/14 care plan approach related to the limited ROM showed the resident was to receive restorative program that included "pulleys, restorator" and ambulation 3 to 5 times per week. The last goal update for this area was on 4/14/14. Review of the medical record failed to	F 282	**F282 Services by Qualified Persons** **Corrective Actions:** Resident's #57, # 68, and #72 are receiving restorative nursing care in accordance to the written care plan. **Others Potentially Affected:** Resident's requiring restorative nursing care have the potential to be affected by this practice. **Systemic Changes:** • Restorative Nursing Aides are assigned to provide restorative care to recommended residents. • An audit will be completed by the Restorative Nurse/designee on Restorative Services and Restorative care plans by ~~01/28/2015~~. 1/18/15 • The Staffing Coordinator and Licensed Nurses will be educated regarding the practice of staffing required in the Restorative Nursing Program. **Monitoring:** The Restorative RN will audit restorative program compliance weekly x 4 weeks, monthly x 3 months, and then quarterly thereafter.	1/18/2015

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F 282	Continued From page 9 show evidence of participation in restorative services. 3. Review of the quarterly MDS assessment dated 9/9/14 revealed resident #68 had diagnoses that included paraplegia, depression, and pain; and was alert and oriented with a BIMS score of 15. Review of the care plan dated 6/29/13 revealed the resident was to receive restorative nursing services to include "pulleys and T-band 3-5 times a week and PRN [as needed]", as well as "hot packs", with a goal of postponing further decline in strength in the residents upper extremities. Review of the restorative nursing documentation revealed the resident only received services twice in November 2014, on 11/13 and 11/14, with no documented refusals by the resident. Interview with the DON and RN #2 on 12/3/14 at 11:20 AM verified documentation of restorative services was lacking. This was attributed to the restorative program being only sporadically provided due to a shortage of staff for the past 4 months. The DON verified on 12/4/14 at 1:35 PM the care plan was to be followed.	F 282	**QA:** The Restorative RN will report audit data to the Quality Assurance Committee quarterly. The Quality Assurance Committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful.	
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	**F309 Provide Care/Services for Highest Well Being** **Corrective Actions:** Resident #64's wound (skin tear) has resolved as of 12/3/2014. **Others Potentially Affected:** The DNS/designee will audit all residents currently receiving wound treatments to identify any other residents affected by this practice. No other residents were identified as having been affected by this practice.	1/18/2015

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F 309	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, staff interview and review of policies and procedures, the facility failed to ensure wounds were monitored until they were healed for 1 of 1 sample resident (#64) observed with wounds. The findings were: Review of the medical record showed resident #64 had diagnoses that included convulsions and heart failure. The following concerns were identified: a. Observation on 12/3/14 at 8:50 PM showed the resident had a dressing on his/her left forearm dated 11/18/14 (15 days previous). Interview that day at 9:55 PM with RN #3 confirmed the dressing needed to be changed. b. Review of the nursing note dated 11/18/14 indicated the resident obtained a skin tear located on the left outer forearm. The wound was cleansed and a Tegaderm dressing was applied. Further review of the notes showed the wound was assessed on 11/19/14 and 11/20/14. There were no further notes regarding the wound until 12/3/14 when the dressing was changed, 15 days after the initial assessment. c. Review of the skin care policy and procedure, last revised in 2013, showed; "If a skin issue is noted, a skin treatment will be started..." Further, "A skin treatment record will be started, and documentation on the skin issue will be done daily with a weekly summary until healed." d. Interview with the DON and corporate nurse on 12/4/14 at 1:50 PM confirmed wounds were to be monitored and observations documented until wounds were healed.	F 309	**Systemic Changes:** • The DNS/designee will re-educate all Licensed Nurses on professional standards for providing wound care and following physician's orders. • The Licensed Nurses will provide wound treatment as ordered by the physician. **Monitoring:** DNS/designee will perform a wound care audit weekly x 4 weeks, then monthly x 3 months, then random thereafter. **QA:** The DNS/designee will report audit data to the Quality Assurance Committee quarterly. The quality assurance committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful.	
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312		

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F 312 SS=D	Continued From page 11 DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, staff interview and review of competency checklists, the facility failed to ensure adequate incontinence care was provided for 2 of 6 sample residents (#64, #68) observed for incontinence care. The findings were: 1. Review of the 9/2/14 quarterly MDS assessment showed resident #64 had diagnoses that included mental deficiency. Further, the resident required extensive assistance with toilet use and was totally dependent on staff for personal hygiene. Observation on 12/2/14 at 8:35 AM showed CNA #7 transferred the resident with a sit-to-stand lift to the bathroom. The CNA removed the resident's incontinence pad and, after changing her gloves, stood behind the resident and reached between the resident's legs and cleansed the perineum and the buttocks from anterior to posterior (front to back), swiping the areas 3 times. 2. Review of the 9/23/14 quarterly MDS assessment showed resident #68 had diagnoses that included paraplegia (paralysis of the lower portion of the body). Further, the resident required extensive assistance with toileting and personal hygiene. Observation on 12/1/14 at 3:30	F 312	**F312 ADL Care for Dependent Residents** **Corrective Actions:** Resident's # 64 and #68 are receiving the necessary incontinence care to meet the resident's needs. **Others Potentially Affected:** An audit will be completed by the DNS/designee on pericare for dependent residents. Dependent residents who are incontinent have the potential to be affected by this practice. **Systemic Changes:** • The DNS/designee will re-educate the CNA's on the practice of providing pericare on the residents. • The CNA's will perform a Pericare Competency and successfully perform pericare on a dependent resident. • The Licensed Nurses will be re-educated on the supervisory role of monitoring CNA's during resident care. **Monitoring:** The DNS/designee will audit resident pericare on 8 random residents each week x 4 weeks, then monthly x 3 months, and then quarterly.	1/10/2015

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F 312	Continued From page 12 PM showed CNA #26 completed incontinence care. The CNA cleansed only the left anterior perineum and not the right perineum, upper thighs or lower abdomen where urine may have come in contact with the skin. She then turned the resident to his/her side and cleansed the buttocks. 3. Review of the peri-care (perineum care) competency checklist, undated, showed the perineum was to be washed front to back, cleansing the middle of the labia then each side for females. For male residents, wash the tip, then the shaft and scrotal sacks. After washing the anterior perineum, the buttocks are to be cleansed. 4. During an interview with the DON on 12/4/14, she acknowledged the incontinence care provided was inadequate and incomplete.	F 312	**QA:** The DNS will report audit data to the Quality Assurance Committee quarterly. The Quality Assurance Committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful.	
F 318 SS=G	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and staff and family interview, the facility failed to ensure a restorative nursing program was provided to increase ROM and/or prevent further	F 318	**F318 Increase/Prevent Decrease in Range of Motion** **Corrective Actions:** • Restorative Services are being provided for residents #3, #4, #43, #44, #57, #68, #71, and #72, and #7. • Resident #44 is receiving skilled therapy services. • Certified Nursing Assistants have been hired by the facility to fill open direct care positions; thus providing necessary staff to provide restorative nursing care.	1/19/2015

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F 318	Continued From page 13 decrease in ROM for 9 of 13 sample residents (#3, #4, #7, #43, #44, #57, #68, #71, #72) with ROM limitations. Failure to provide these services resulted in an avoidable functional decline for resident #44. The findings were: 1. Observation on 12/2/14 at 8:30 AM showed resident #44 was transported in a wheelchair to the nurses' station by staff and transferred to a recliner. The resident required extensive assistance to stand and pivot to the recliner. S/he had a brace on the right wrist and bruising on the right side of the face. Review of the medical record showed the resident had diagnoses that included osteoporosis and a right hip fracture that was sustained on 6/17/14. Further, on 11/25/14, the resident was sent to the emergency room after a fall, resulting in a wrist fracture and hematoma to the right side of the head. The following concerns were identified: a. Review of the physical therapy daily treatment note dated 9/15/14 showed the resident was able to ambulate with a FWW (front wheeled walker) and was full weight bearing and balance on the right lower extremity. Further, the resident was able to stand, pivot and transfer from the chair to the wheelchair with only stand by assistance. Observation on 12/2/14 showed the resident required extensive assistance to stand and pivot to the recliner. b. Review of the restorative care communication document dated 9/23/14 showed the resident had made good progress in physical therapy with improved strength and function. Further, regular physical activity was recommended to maintain mobility and strength and was to be done 2 to 3 times a week for strengthening and mobility training. Further, it showed the therapy was to start as soon as	F 318	**Others Potentially Affected:** An audit will be completed on Restorative Services and Restorative care plans by the Restorative Nurse. Residents with recommendations for Restorative Nursing have the potential to be affected by this practice. **Systemic Changes:** • Restorative Nursing Aides are assigned to provide restorative care to recommended residents. • An audit will be completed by the Restorative Nurse/designee on Restorative Services and restorative care plans by ~~01/28/2015~~. 1/18/15. a • The Staffing Coordinator and Licensed Nurses will be educated regarding the practice of staffing required in the Restorative Nursing Program. • The Restorative Nurse and Skilled Therapist will collaborate to re-write accurate restorative programs by ~~01/28/2015~~. 1/18/15. • The Nursing Department will be educated on the Restorative Program, restorative care guidelines, range of motion, and reporting resident functional decline by ~~01/28/2015~~. 1/18/15 a • ~~Restorative recommendations will be input into the electronic health record by 01/28/2015.~~ 1/18/15 a Restorative recommendations will be input into the electronic health record by 1/18/15. a	

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F 318	Continued From page 14 possible. Review of the restorative log calendar for November and December 2014 did not show any restorative therapy was provided. c. Interview with the resident's family member on 12/1/14 at 3:15 PM revealed there was a problem with the rehabilitation program for the facility. The family member indicated the resident was no longer provided an opportunity to exercise. The resident sat at the nurse's station in a recliner most of the time for supervision due to the history of falls. d. Review of the 10/2/14 quarterly MDS assessment, section G, showed the resident required extensive assistance with transfers and walking in his/her room. Further, section O showed there were no restorative activities performed during the observation period. e. During an interview with the restorative nurse on 12/4/14 at 1:15 PM, she acknowledged the resident had not been provided restorative therapy and had declined. 2. Review of the medical record showed resident #43 had diagnoses that included peripheral vascular disease and tremors. Observation on 12/3/14 at 3:40 PM showed resident #43 sat in a wheelchair in the common area of the secure unit and stood upright unassisted. CNA #6, who had observed the resident standing, instructed him/her to sit back down in the chair and then provided coffee to the resident. During an interview with CNA #6 on 12/3/14 at 3:50 PM, she indicated the resident walked very little. Further, the resident had a walker in his/her room and only ambulated to the bathroom. Review of the functional mobility and safety screen dated 10/3/14 showed the resident needed stretching and ROM for the knees and shoulders. Further, for restorative care, the screening tool showed	F 318	**Monitoring:** The Restorative RN will audit restorative program compliance weekly x 4 weeks, monthly x 3 months, and then quarterly thereafter. **QA:** The Restorative RN will report audit data to the Quality Assurance Committee quarterly. The quality assurance committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful.	

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F 318	Continued From page 15 the resident would benefit from a walking program with upper and lower extremity exercises. Review of the 10/16/14 quarterly MDS assessment, section O, showed there were no restorative exercises provided. 3. Medical record review for resident #3 showed diagnoses that included right below the knee amputation and peripheral vascular disease. Review of the functional mobility and safety screen dated 10/24/14 showed s/he had developed tightness of the lower extremities and elbows. Further, restorative care was to include upper and lower extremity ROM exercises. Review of the 10/29/14 quarterly MDS assessment showed there was no restorative exercises provided. Review of the care plan, last updated on 10/29/14, failed to show the resident was on a restorative program to include the recommended exercises. 4. Review of the 1/23/14 annual MDS assessment showed resident #57 had bilateral ROM limitations of the lower extremities. There were also ROM limitations on one side of the upper extremities. The 8/1/14 care plan approach related to the limited ROM showed the resident was to receive a "level one" restorative program that included ambulation. In addition, an older approach dated 4/19/13 showed passive ROM to upper extremities and ambulate with assistance of one 2-3 times a week. Review of the medical record failed to show evidence of participation in restorative services. 5. Review of the 10/23/14 annual MDS assessment showed resident #72 had bilateral ROM limitations for both upper and lower extremities. The 1/28/14 care plan approach	F 318		

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F 318	Continued From page 16 related to the limited ROM showed the resident was to receive restorative program that included "pulleys, restorator" and ambulation 3 to 5 times per week. The last goal update for this area was on 4/14/14. Review of the medical record failed to show evidence of participation in restorative services. 6. Review of the quarterly MDS assessment dated 9/9/14 revealed resident #68 had diagnoses that included paraplegia, depression, and pain; and was alert and oriented with a BIMS score of 15. Review of the care plan dated 5/29/13 revealed the resident was to receive restorative nursing services to include pulleys and T-band 3-5 times a week and PRN, as well as hot packs, with a goal of postponing further decline in strength in upper extremities. Review of the restorative nursing documentation revealed the resident only received services twice in November 2014, on 11/13 and 11/14, with no documented refusals by the resident. 7. Review of the 10/23/14 quarterly MDS assessment showed resident #71 had bilateral ROM limitations of the upper and lower extremities. Review of the handwritten list of restorative orders provided by the facility showed the resident was to be receiving restorative nursing services, specifically walking. Review of the resident's care plan for ADLs, last updated 10/30/14, failed to show the resident was on a restorative program, and gave no instructions for assisting the resident with ambulation. Review of restorative charting showed no restorative nursing documentation after 3/24/14. 8. Review of the 11/7/14 quarterly MDS assessment showed resident #7 had bilateral	F 318		

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F 318	Continued From page 17 ROM limitations of the upper and lower extremities. Review of the handwritten list of restorative orders provided by the facility showed the resident was to be receiving restorative nursing services, specifically "benefit from LE [lower extremity] ROM in hips and knees extension, assist walking from restorative if [s/he] allowed it 3 X [times] wk [week] 10 min. [minutes]." Review of the resident's care plan for ADLs, last updated 11/14/14, failed to show the resident was on a restorative program, and gave no instructions for assisting the resident with restorative exercises. Review of restorative charting showed no restorative nursing documentation after 8/16/13. 9. Review of the 11/16/14 quarterly MDS assessment showed resident #4 had bilateral ROM limitations of the upper and lower extremities. Review of facility documentation showed the resident was to be receiving restorative nursing services, specifically "continue walking daily 5 min [minutes]." Review of the resident's care plan for ADLs, last updated 11/24/14, failed to show the resident was on a restorative program, and gave no instructions for assisting the resident with ambulation. Review of restorative charting showed no restorative nursing documentation after 9/22/14. 10. Review of a hand written list provided by the facility revealed 39 residents were assessed as needing restorative services. Interview with the DON and RN #2 on 12/3/14 at 11:20 AM verified documentation related to the restorative services was lacking as a result of the restorative program being only sporadically provided. The program was unable to be	F 318		

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F 318	Continued From page 18 performed due to a shortage of staff for the past 4 months. The interview further revealed restorative CNAs were being pulled from their restorative duties in order to work the floor, the CNAs provided what restorative they could for residents if time permitted, and there was no monitoring in place to identify residents who may be showing decline in functional abilities.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, staff interview and review of manufacturer's instruction guidelines, the facility failed to ensure residents were transported safely and evaluated for the appropriate use of the sit-to-stand lift for 2 of 5 sample residents (#3, #64) observed during sit-to-stand lift transfers. The findings were: 1. Observation on 12/2/14 at 8:35 AM showed CNA #7 transferred resident #64 from the wheelchair to the bathroom with a sit-to-stand lift. The resident was not holding onto the lift bars and dangled his/her arms to the side. Further, the resident was only supported by the sling and did not bear his/her own weight. The CNA at that time indicated the resident did not routinely hold onto	F 323	**F323 Accidents and Hazards** **Corrective Actions:** Residents #3 and #64 have been evaluated for safe transfers and are being safely transferred per policy and manufacturer's guidelines. **Others Potentially Affected:** A transfer evaluation was completed by the Unit Managers on all residents that are transferred using a mechanical lift device. Residents being transferred with a mechanical lift have the potential to be affected by this practice.	1/10/2015

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F 323	Continued From page 19 the bars of the lift. Review of the nurse's note dated 11/21/14 and timed 1:42 PM showed for activities, the resident was unable to bear weight. Review of the instruction guide for the lift showed to assist users into a standing position; "3. Raise the sling bar about 10 to 20 cm [centimeters] (4 to 8 in [inches]). The patient grabs the sling bar. Continue the lifting procedure." 2. Observation on 12/3/14 at 4:35 PM showed CNA #8 and CNA #27 transferred resident #3 from the bed using the sit-to-stand lift. The resident expressed fear of falling during the transfer. The CNAs, at that time, indicated the resident often resisted the use of the lift during transfers. Review of the nurse's notes showed the following: a. On 10/2/14, timed at 10:42 AM, the resident obtained a hematoma while flailing his/her arms during a transfer when the staff were attempting to get the resident to hold onto the lift. b. On 10/10/14, timed at 10:35 AM, the nurse noted bruising to the right and left forearms; 4 on the left and 5 on the right. The note indicated the bruising appeared to be consistent with resisting care and fighting while on the lift. c. On 10/16/14, timed at 5:40 PM, the resident acquired a bruise to the right inner wrist while resisting care. The equipment involved in the incident was the mechanical lift. d. On 10/27/14, timed at 6:07 PM, the previous shift reported the resident had a new bruises on the left and right forearms and left breast. Review of the incident report showed the lift sling was the possible cause. 3. During an interview with the DON and cooperate nurse on 12/4/14 at 1 PM, they acknowledged there was no documentation to	F 323	**Systemic Changes:** • A Transfer Evaluation will be performed upon admission, quarterly, annually, and with significant change. • The DNS/designee will educate the Licensed Nurses to the process of completing Transfer Evaluations and monitoring direct care staff during mechanical lift transfers by ~~01/28/15~~ 1/18/15. • The DNS/designee will re-educate Certified Nursing Assistants on transfers using a mechanical lift device by ~~01/28/15~~. 1/18/15 • The Unit Managers/designee will complete Mechanical Lift Competencies for all Certified Nursing Assistants by 01/28/15, and annually thereafter. • The Unit Managers/designee will update the care plans of all residents who are transferred using a mechanical lift device by ~~01/28/15~~. 1/18/15 **Monitoring:** The DNS/designee will observe a minimum of one mechanical lift transfer for each resident that requires a mechanical lift device for transfer/movement, weekly x 4 weeks, monthly x 3 months, and then random thereafter.	

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F 323	Continued From page 20 show an assessment had been completed indicating the sit-to-stand lift was safe for the residents' use. Further, the residents needed to be evaluated for the appropriate lift to be used during transfers.	F 323	**QA:** The DNS will report mechanical lift observation data to the Quality Assurance Committee quarterly. The quality assurance committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful.	
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 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, review of state survey agency logs and staff	F 329	**F329 Drug Regimen Is Free From Unnecessary Drugs** 1/16/2015 **Corrective Actions:** Resident #7 has been evaluated by the Interdisciplinary Team and Consulting Pharmacist to determine resident needs for the use of Seroquel; make recommendations for a Gradual Dose Reduction; identify specific target behaviors; and develop individualized non-pharmacological interventions. **Others Potentially Affected:** No other residents were identified as having been affected by this practice.	

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F 329	Continued From page 21 interview the facility failed to ensure adequate indications for use and monitoring of psychoactive medications for 1 of 4 sample residents (#7) receiving psychoactive medications. The findings were: Review of the quarterly MDS assessment for resident #7 revealed diagnoses that included non-Alzheimer's dementia and depression. Further review of the assessment showed the resident exhibited both physical and verbal behavioral symptoms 1 to 3 days during the assessment period, and rejected care daily. Review of the resident's care plan for behaviors showed the resident's behaviors were described on 6/20/13 as verbal outbursts, swearing, irritability, agitation, attempts to leave the facility, refusal of cares, rejection of staff's offers to assist with care such as ADLs and especially bathing. Review of the resident's care plan for self care deficit, last updated 11/14/14, revealed the resident did not like to be touched, and that being touched tended to agitate him/her. Review of a physician communication dated 10/17/14 showed the resident had thrown a cup of cold water at resident #4 while they were both sitting at a table in the dining room. The only intervention implemented was to place lids on the resident's cup to protect others. Review of a nursing note dated 10/18/14 at 10:45 PM revealed the resident did not like the coffee cup with a lid, and refused to drink coffee at supper that evening. Review of a physician communication dated 11/14/14 showed the resident had thrown coffee at resident #4 when that resident attempted to touch him/her. The only intervention implemented	F 329	**Systemic Changes:** • The DNS/designee will complete an audit on all residents receiving Antipsychotic drugs by ~~01/28/15~~, to identify target behaviors, non-pharmacological interventions, and potential GDR's that need updated. • A new process has been developed where the Interdisciplinary Team will meet weekly to discuss residents who are receiving psychotropic medications, target behaviors, behavior monitoring, and gradual dose reduction recommendations. • The Psychotropic Committee will make recommendations to the attending physician for GDR's. • The DNS/designee will educate the Licensed Nurses on the process for evaluating and documenting resident behaviors and recommendations for psychotropic medications by ~~01/28/15~~. 1/18/15. • All physician orders are being reviewed at the morning Clinical meeting to determine resident needs, care planning, and potential further evaluations that need to be completed.	1/18/15

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F 329	Continued From page 22 was to add Seroquel (an anti-psychotic) 25 mg by mouth twice daily to the resident's medication regimen for resident #7. Review of state survey agency logs showed the resident had altercations with resident (#4) two additional times, on 8/14/14 and 9/21/14. Observation on 12/2/14 beginning at 8:15 AM showed resident #4, who was seated close to resident #7 at the time, reached out to grab and shake resident #7's shoulder several times. Resident #7 was visibly agitated when this happened and started to throw his/her drink at resident #4. Staff did not intervene or move either resident. Review of the medical record showed no evidence the resident's altercations with one specific resident (#4) were evaluated or addressed. There was no evidence facility staff considered resident #4's propensity for touching other residents as a trigger to resident #7's behaviors. There was no evidence non-pharmacological interventions were considered. Interview with unit manager #1 on 12/4/14 at 8:35 AM revealed residents chose where they sat in the dining room, and staff had no instructions to redirect residents who were known to agitate others to tables where they would be welcomed. The unit manager further stated the facility did not have "specific target behaviors" they were monitoring in connection with the resident's psychoactive medications. Interview with the social worker on 12/4/14 at 11:40 AM revealed he had not been involved in	F 329	**Monitoring:** The DNS/designee will complete a monthly audit of Psychotropic Medications to identify any potential components that may need improvement (i.e. behavior monitoring, individualized target behaviors, non-pharmacological interventions, gradual dose reductions, etc.) **QA:** The DNS/designee will report audit date to the Quality Assurance Committee on a quarterly basis. The quality assurance committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful.	

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F 329	Continued From page 23 discussions about the resident throwing drinks before the Seroquel was ordered, and confirmed non-pharmacological interventions should have been tried before adding an anti-psychotic to the resident's medication regimen.	F 329		
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 error rate under 5%. Two medication errors were observed out of 28 opportunities for error, which resulted in an error rate of 7.1%. The findings were: 1. Observation on 12/2/14 at 11 AM showed RN #4 gave resident #66 calcium 500 mg (milligrams) and vitamin D 400 IU (international units). Review of the physician orders dated 9/23/14 showed the resident was to receive calcium 500 mg and Vitamin D 125 units 3 times each day. During an interview with RN #6 on 12/3/14 at 8:40 AM, she verified the dose the resident received was vitamin D 400 units and not 125 units. Further, she confirmed the resident was given the incorrect dose. 2. Observation on 12/3/14 at 7:15 AM showed RN #5 gave resident #70 vitamin B-1 (thiamine) 100 mg with calcium 180 mg. Review of the physician order dated 10/27/14 showed the resident was	F 332	**F332 Free of Medication Error Rates of 5% or more** 1/15/2015 **Corrective Actions:** Resident #4 is receiving the proper dose of Calcium/Vitamin D, per physician orders. Resident #5 is receiving the proper dose of Thiamine, per physician orders. **Others Potentially Affected:** 1/8/15 An audit was completed on ~~01/28/15~~ by the Unit Manager/designee regarding dosing of Calcium/Vitamin D and Thiamine. Residents receiving Calcium/Vitamin D or Thiamine have the potential to be affected. **Systemic Changes:** • The facility has developed a process where the physician is notified of available dosing of Calcium/Vitamin D and Thiamine products. • Clarification orders have been received for all resident's receiving Calcium/Vitamin D or Thiamine products.	

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F 332	Continued From page 24 prescribed thiamine 100 mg without calcium. Interview with RN #6 at 8:13 AM that day confirmed the resident was to be administered the thiamine without calcium and confirmed the incorrect medication was given.	F 332	• The DNS/designee will educate the licensed nurses on receiving physician orders containing Calcium/Vitamin D or Thiamine products, by ~~01/28/15~~ 1/18/15 • A two-nurse verification system will be utilized on all newly received medications orders. • New physician orders will be reviewed daily (Monday through Friday) at the daily clinical meeting for accuracy and transcription. **Monitoring:** An audit will be completed by the Unit Manager/designee on all new medication orders on a weekly basis x 4 weeks, monthly x 3 months, and then random thereafter. **QA:** The DNS will present the audit data to the Quality Assurance Committee quarterly. The quality assurance committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful.	
F 353 SS=F	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. 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, medical record review, staff interview, resident interview, family interview, and review of staffing sheets, the facility failed to ensure adequate nursing staff to provide necessary care and services for residents. The	F 353		

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F 353	Continued From page 25 resident census was 77. The findings were: 1. Interview with the DON and RN #2 on 12/3/14 at 11:20 AM verified documentation related to the provision of restorative services was lacking due to the restorative program being only sporadically provided. The program was unable to be provided regularly due to a shortage of staff for the past 4 months. The interview further revealed the CNAs provided what they could for residents if time permitted, and there was no monitoring in place to identify residents who may be showing decline in functional abilities. Review of a hand written list provided by the facility revealed 39 residents were assessed as needing restorative services. Resident #44 was identified as having avoidable decline in functional ability related to the lack of services. Refer to F318 for details. 2. Review of the staffing sheets from November and December 2014 showed the facility's day shift and night shift plan for staffing was not being met. For each date, there were hours that could not be filled due to CNA shortages. These shortages varied in number of hours and across the four units. Interview with the DON on 12/4/14 at 10:45 AM verified the staffing plan for each unit was not always able to be filled. There were vacancies and staff were "shuffled" around where needed. During a later interview with the DON on 12/4/14 at 1:35 PM she stated they had vacancies and were attempting to fill 5 full time positions (4 CNAs and one nurse). 3. The facility's plan for staffing the memory care unit for the day shift was to have 2 CNAs working from 5 AM to 5:30 PM and one CNA from 5 AM to 1:30 PM. On 11/2, 11/5, 11/6, 11/9, 11/11, 11/14, 11/16, 11/17, 11/18, 11/20, 11/22, 11/23, 11/24,	F 353	**F353 Sufficient 24-hr Nursing Staff** **Corrective Actions:** • The facility has sufficient nursing staff to provide nursing and related services as needed by the residents, on all units of the facility. • Five Certified Nursing Assistants have been hired by the facility to fill open direct care positions; thus providing necessary staff to provide restorative nursing care. • Resident #44 is receiving skilled therapy services. **Others Potentially Affected:** All residents have the potential to be affected by this practice. **Systemic Changes:** • The DNS has educated the Staffing Coordinator/Scheduler regarding adequate staffing patterns for direct care and restorative care. • The facility in collaboration with the Recruiter will advertise and recruit new staff as indicated. • A daily meeting has been implemented where staffing needs are identified and remediated. • The scheduler will notify the DON/Administrator when the nursing schedule is complete each month, for review of potential staffing needs.	1/16/2015

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F 363	Continued From page 26 11/26, 11/27, 11/28, 11/29, and 11/30 the 5 AM to 1:30 PM shift was lacking some or all of the hours. In addition, the facility's plan for staffing the night shift on the memory care unit was 2 CNAs from 5 PM to 5:30 AM, and 1 CNA from 5 PM to 9:30 PM. On 11/21, 11/22, and 11/23 there was only 1 CNA for the entire night shift, and according to the staffing sheets the CNA was on light duty. 4. Observation on the night shift of 12/3/14 from 8:30 PM to 10:15 PM showed the following shortages: a. The 1 PM to 9:30 PM shift was unable to be filled on the 200 hall unit, leaving 1 CNA from 5 PM to 5:30 AM. The census of the unit was 21 residents. b. The 1 PM to 9:30 PM shift on the 500 hall unit was vacant and one of two 5 PM to 5:30 AM shifts was vacant for 6.5 hours from 11 PM to 5:30 AM. This left 1 CNA on the unit from 11 PM to 5 AM. The 500 hall unit had a census of 23 residents. c. The 400 hall unit 5:30 PM to 5 AM CNA shift was vacant from 1 AM to 5 AM (4 hours). In addition the 400 hall nurse shift from 1 PM to 9:30 AM was vacant. Interview with LPN #1 at 8:45 PM revealed she was taking care of the 300 hall and half of the 400 hall, the other half of the 400 hall was taken care of by the 200 hall unit nurse on duty. 6. Interview with a family member on 12/3/14 at 12:50 PM revealed s/he was concerned about resident safety on the 500 hall at night. The family member stated s/he was at the facility regularly until 8:30 PM or later and the residents in the 500 hall milieu were often unsupervised. Further, the family member stated restorative nursing "had not	F 363	**Monitoring:** A daily meeting has been implemented where staffing needs are identified and remediated. The scheduler will notify the DON/Administrator when the nursing schedule is complete each month, for review of potential staffing needs. **QA:** The DNS will report nursing staff openings to the Quality Assurance Committee quarterly. The Quality Assurance Committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful.	

11/21/15

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F 353	Continued From page 27 been happening" for his/her family member, and that the restorative aides had been used as floor aides for approximately 4 months. 6. Review of the quarterly MDS assessment dated 9/9/14 revealed resident #68 had diagnoses that included paraplegia, depression, and pain; and was alert and oriented with a BIMS score of 15. Further review revealed the resident needed total assistance with transfers. The following concerns were noted: a. Observation on 12/3/14 at 10:10 PM showed the resident in his/her wheelchair in his/her room. Interview on 12/4/14 at 9 AM with the resident revealed the resident had to wait "a while" to get help to go to bed the evening before; it is a recurring problem because the CNAs have to get their computer charting finished before midnight and it takes two CNAs to operate the Hoyer lift. b. Interview on 12/4/14 at 9:30 AM with unit manager #2 revealed the expectation was for the CNAs to assist the resident into bed before the computer charting was done. c. During interview with resident #68 on 12/1/14 at 3:20 PM the resident indicated s/he was paralyzed from the waist down and wanted the exercise program previously offered to resume. The resident further revealed the exercises helped reduce neck and shoulder pain.	F 353		
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	F 356	**F356 Posted Nurse Staffing Information** **Corrective Actions:** The facility is posting the total number of nursing staff and their actual hours at the beginning of each shift worked.	1/18/2015

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F 356	Continued From page 28 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. 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 staff interview and review of the daily nurse staffing sheets, the facility failed to ensure 18 months of nurse staffing data were maintained and available for review. The findings were: Review of the daily nurse staffing sheets revealed there were only 12 months of data available. Further review showed that of the months that were available, data was missing. For the month of June 2014, only 8 days of data were available for review; May 2014 had 14 days of data	F 356	**Others Potentially Affected:** ~~No residents were identified as affected by this practice.~~ All residents have the potential to be affected by this practice. **Systemic Changes:** • The DNS/designee has educated the Staffing Coordinator/Scheduler to post the total number of nursing staff and their actual hours at the beginning of each shift, including changes related to staffing changes. • The DNS/designee will educate the Licensed Nurses on the regulation and requirement to save the Daily Nurse Staffing posting. • The Staffing Coordinator/Scheduler will save the Daily Nurse Posting sheets in a designated area and maintain for the required timeframe. **Monitoring:** The Staffing Coordinator/Scheduler will audit Daily Nurse Posting sheets weekly x 4 weeks, monthly x 3 months, and then monthly for compliance with the regulation.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING _____ B. WING _____	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN HEALTHCARE COMMUNITY	2009 LARAMIE STREET TORRINGTON, WY 82240

(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 366	Continued From page 29 available; and April 2014 had 9 days of data available. Interview with the DON on 12/4/14 at 10:55 AM, confirmed the facility did not have 18 months of daily staffing data.	F 366	**QA:** The Staffing Coordinator/Scheduler will report audit data to the Quality Assurance Committee on a quarterly basis.	
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the menu and resident diet order list, the facility failed to ensure the menu was followed in 1 of 3 dining rooms for content and portions of food items. The findings were: Review of the planned lunch menu for 12/3/14 showed chicken strips 3 ounces (oz), steak fries 1/2 cup, peas and carrots 1/2 cup, and mixed berries with yogurt 1/2 cup. These items and portions were the same for both the regular texture and the puree textured diets. The following concerns were identified: a. Observation on 12/3/14 at 12:05 PM in the memory care dining room showed the mixed berries and yogurt were not included for any of the resident meals. Review of a 12/3/14 updated diet order list provided by the registered dietitian (RD) showed there were 23 residents in the memory care unit. b. The portion size served for the pureed	F 363	The Quality Assurance Committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful. **F363 Menus Meet Res Needs/Prep in Advance/Followed** **Corrective Actions:** The facility follows the approved menu for all dining rooms, in content and portion. Resident's #9, #11, #41, #71, and #75 are being served the appropriate portion of all menu items. **Others Potentially Affected:** Residents on pureed diets and those on the Memory Care Unit have the potential to be affected by this practice. **Systemic Changes:** • The Registered Dietician/designee will educate the dietary staff on following menus and portion size by ~~01/28/15.~~ 1/18/15.	01/18/2015

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F 363	Continued From page 30 items were less than planned. The pureed chicken, potatoes, and vegetable portions were 1/4 cup (2 ounces) for each of the three items. Review of a 12/3/14 updated diet order list provided by the RD showed there were 5 residents with pureed diets (#9, #11, #41, #71, #75). a. Interview with the RD on 12/3/14 at 1:10 PM revealed the menu, including portion sizes, should have been followed and she was uncertain why it had not been followed.	F 363	• The Registered Dietician/designee will educate the nursing staff to notify the serving staff if food items are missing from the tray. **Monitoring:** The Registered Dietician/designee will audit meal service daily (random meals/random dining rooms) for proper portions and following the menu x 2 weeks, then weekly x 4 weeks, and monthly x 3 months, and random thereafter.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions 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 2 food preparation areas (500 hall kitchen) and 1 resident food storage area (room #411). The findings were: 1. Observations during the lunch food service on 12/3/14 in the memory care unit showed the following concerns with hand hygiene: a. At 11:50 AM dietary aide #1 put on a hair net and proceeded, without performing hand	F 371	**QA:** The Registered Dietician will report audit data to the Quality Assurance Committee on a quarterly basis. The Quality Assurance Committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful.	

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F 371	Continued From page 31 washing, to pour beverages into glasses for residents. b. At 11:50 AM the cook handled the refrigerator door multiple times retrieving items to make a sandwich. The cook then donned gloves and made the sandwich without performing hand washing. c. At 12:05 PM dietary aide #2 entered into the back of the kitchen and, without any hand washing, donned gloves and prepared a food tray for a resident. According to Food Code 2013, U.S. Public Health Service, 2-301.14 When to Wash: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms... "(E) After handling soiled EQUIPMENT or UTENSILS...(H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands 2. Observation on 12/1/14 at 11:20 AM, and on 12/3/14 at 11:45 AM showed the following items in the memory care kitchen were in need of cleaning or repair: a. The vents of the hood system above the range were soiled with visible grease and dust. b. The microwave was soiled with dried splattered food on the interior walls. c. A coffee pot used for decaffeinated coffee had a broken plastic spout and was in use during both observations. 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. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil	F 371	**F371 Food Procure, Store/Prepare/Serve-Sanitary** **Corrective Actions:** • The facility provides a sanitary environment in food preparation areas. • The food within the refrigerator was discarded prior to putting the new refrigerator into service. • The refrigerator for room #411 was replaced on 12/2/2014, with a new refrigerator. Thermometer was placed in refrigerator and verified proper functioning of the new refrigerator, by the Registered Dietician. **Others Potentially Affected:** The resident's residing on the 500 unit have the potential to be affected by this practice. **Systemic Changes:** • The Registered Dietician/designee will educated the dietary staff on hand hygiene and proper glove use. • The vent/hood system on the Memory Care Unit was cleaned of visible grease and dust. • The microwave in the Memory Care Unit was cleaned.	1/15/2015

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F 371	Continued From page 32 accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." According to Food Code 2013, U.S. Public Health Service: 4-202.11: "(A) Multiuse FOOD-CONTACT SURFACES shall be: (1) SMOOTH; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections; (3) Free of sharp internal angles, corners, and crevices; (4) Finished to have SMOOTH welds and joints..." 3. Interview with the RD on 12/3/14 at 1:10 PM revealed cleaning of the kitchen needed to be done more frequently. Further, she was unaware of the condition of the coffee pot. She also verified the facility expectation was that hand washing would be done prior to donning gloves. 4. Observation on 12/2/14 at 8:40 AM of the small refrigerator in room #411 showed it was filled with unlabeled food items. There was no thermometer. Interview with the RD on 12/2/14 at 9 AM verified the facility staff did not monitor the refrigerator. The RD stated she would get the temperature. Interview with the RD on 12/3/14 at 10:08 AM verified the temperature in the refrigerator was 45 degrees Fahrenheit when tested, and this was at the coldest setting. It was found the refrigerator was unable to keep the food at a safe temperature. She then stated the food items in the refrigerator had been discarded and a new refrigerator was provided with a plan for monitoring the refrigerator temperature by the staff. According to Food Code 2013, U.S. Public Health Service: 4-204.112	F 371	• The coffee pot with the broken plastic spout was removed from service on 12/4/2014. **Monitoring:** The Registered Dietician/designee will perform kitchen/server cleanliness/equipment audits weekly x 4 weeks, monthly x 3 months, and random thereafter. **QA:** The Registered Dietician will report audit data to the Quality Assurance Committee on a quarterly basis. The Quality Assurance Committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful.	

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F 371	Continued From page 33 (B) Except as specified in ¶ (C) of this section, cold or hot holding EQUIPMENT used for TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be designed to include and shall be equipped with at least one integral or permanently affixed TEMPERATURE MEASURING DEVICE that is located to allow easy viewing of the device's temperature display.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and other drugs subject to	F 431	**F431 Label/Store Drugs & Biologicals** 1/18/2015 **Corrective Actions:** The expired medications and medications without expiration dates on the labels were removed from medication carts and medication rooms on 12/04/2014. **Others Potentially Affected:** An audit was conducted on all medication carts and medication rooms, for the purpose of identifying expired medications or medications without expiration date on the label, on ~~01/28/15.~~ 1/18/15. No other residents were identified as having been affected by this practice.	

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F 431	Continued From page 34 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure expired medications and medications lacking expiration dates were not available for resident administration in 2 of 4 medication rooms. The findings were: 1. Observation of the medication room and cart located in the 300 hallway on 12/2/14 at 2:10 PM with RN #4 revealed 2 cassettes of Tramadol 50 mg (milligrams) with 8 tablets in each. The medications were not labeled with an expiration date. In addition, 2 cassettes of the medication hydrocodone 5 mg with acetaminophen 325 mg, containing 8 tablets each, were not labeled with an expiration date. Interview with RN #4 at the time of the observation confirmed the medications were not labeled with the expiration date and were available for use. 2. Observation of the medication room and cart located in the 200 hallway on 12/2/14 at 2:30 PM with RN #6 showed 1 cassette each of hydrocodone 5 mg with acetaminophen 324 mg containing 8 tablets and Tramadol 50 mg with 2 remaining tablets were not labeled with an expiration date. Interview with RN #6 at the time of the observation confirmed the cassettes were not labeled with the expiration date and were available for use. Additionally, a cassette containing the medication oxycodone with	F 431	**Systemic Changes:** • The DNS/designee will educate the licensed nurses on medication expiration dates and checking labels for expiration dates upon receipt of weekly cycle medications, by ~~01/28/2015~~. 1/18/15. • Resident cycle medications will be checked for expiration dates on the label prior to being put into the medication cart for administration. • A process has been implemented where the medication rooms will be checked on a weekly basis for expired medications. **Monitoring:** The Unit Manager/designee will perform a medication room audit to identify and remove any expired medications, weekly x 4 weeks, monthly x 3 months, and then random thereafter. **QA:** The UM's will report audit data quarterly to the Quality Assurance Committee. The Quality Assurance Committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful.	

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GOSHEN HEALTHCARE COMMUNITY	2609 LARAMIE STREET TORRINGTON, WY 82240

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F 431	Continued From page 35 acetaminophen, holding 16 tablets, had a use by date of 1/11/14 (expired by 10.5 months). Another cassette with the medication Tramadol 50 mg had a use by date of 7/15/14 (expired by over 4 months). Interview with RN #6 at the time of the observation confirmed the medications had expired and were still available for use.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (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	F 441	**F441 Infection Control, Prevent Spread, Linens** 1/18/2015 **Corrective Actions:** The facility has established an Infection Control Program that investigates, controls, and prevents infection within the facility; including a method to track and trend infections, incl. residents #3, #4, #64, #66, #72, #27, #37, #63 and #65. The facility staff perform hand hygiene appropriately during their work shift for all residents, including residents #3, #4, #64, #66, #72, #27, #37, #63 and #65. **Others Potentially Affected:** All residents have the potential to be affected by this practice.	

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F 441	Continued From page 36 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 review of infection control program information, observation, and staff interview, the facility failed to establish an infection control program that included a record of incidents and corrective actions related to infections. In addition, hand hygiene concerns were identified during random resident care observations affecting 5 sample residents (#3, #4, #64, #68, #72) and 4 non-sample residents (#27, #37, #63, #65). The findings were: 1. Review of the infection control program information showed there was no record of resident infections, what their treatments included, if they were cultured, and when the infections were resolved. Interview with the DON on 12/4/14 beginning at 1 PM revealed she was newly in charge of the program and there were parts not yet implemented. She stated resident infections were discussed and tracked daily on an erasable board. In addition, there was a weekly meeting where infections were reviewed with the nursing team members. Historical information was not available related to resident infections. Review of available information showed 4 residents were being treated for urinary tract infections at that time.	F 441	**Systemic Changes:** • The DNS and Unit Managers were educated on the elements of an Infection Control Program by ~~01/28/15~~. 1/18/15. • The DNS/designee will educate the licensed nurses on infection control practices to prevent the spread of infection by ~~01/28/15~~. 1/18/15 • The DNS/designee will educate the CNA's on infection control, hand hygiene during resident care, glove use, and hand hygiene during meal service by ~~01/28/15~~. 1/18/15. • The Nursing Staff will pass the Hand Hygiene Competency by ~~01/28/15~~. 1/18/15. • Hand Hygiene Competencies will be completed upon new hire, annually, and as indicated. • The DNS/designee will educate the CNA's on handling of linens and mechanical lift slings by ~~01/28/15~~. 1/18/15. • The Infection Control Report has been implemented, as of 12/19/2014.	

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F 441	Continued From page 37 2. Observation on 12/3/14 at 11:55 AM showed CNA #9 assisting residents #3, #37 and #63 in the dining room during lunch. The residents were sitting at the same table. The CNA cut up the resident's food with the same silverware the residents had used, while also adjusting clothing protectors and touching each resident at the table. CNA# 10 was observed at 12 PM during the same meal assisting residents #27 and #72. The CNA cut up the resident's food after the resident had handled the silverware and then continued to assist the other resident sitting at the table, adjusting the clothing. Neither CNA performed hand hygiene between residents. During an interview with CNA #9 at 12:13 PM that same day, she revealed she did not realize the need to perform hand hygiene between residents, only between tables with residents. 3. Review of the quarterly MDS assessment dated 8/24/14 revealed resident #64 had diagnoses that included unspecified intellectual disabilities; and needed extensive assistance with transfers and toilet use. The following concerns were noted: a. Observation on 12/2/14 at 8:35 AM showed CNA #7 provided incontinence care for resident #64. After providing care, the CNA removed her gloves and transferred the resident to bed with the use of a sit-to-stand lift. After removing the lift sling from around the resident, she threw it on the floor. She then continued to provide care, repositioning the resident in bed, replaced the fall mat on the floor beside the bed and then covered the resident with blankets. She did not cleanse her hands after removing her gloves and before continuing with resident care. In addition, the sling thrown on the floor was picked up by the CNA and draped over the lift and placed in the hallway.	F 441	**Monitoring:** The DNS/designee will audit resident infections for tracking/trending, weekly x 4 weeks, and then monthly thereafter. **QA:** The DNS will report audit data quarterly to the Quality Assurance Committee. The Quality Assurance Committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful.	

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F 441	Continued From page 38 The sling was not cleaned or replaced after it had been on the floor. b. Observation on 12/3/14 at 8:50 PM showed CNA #11 transferred resident #64 in a sit-to-stand lift from wheelchair to the toilet. The CNA performed mouth care, removed gloves, did not perform hand hygiene, donned new gloves, wiped the resident's perineum front to back, did not remove her gloves, proceeded to place a new brief, and transferred the resident from the bathroom to the bed, lowered the resident to the bed, and then removed gloves and performed hand hygiene. Interview with CNA #11 on 12/3/14 at 9:46 PM revealed she forgot to perform adequate hand hygiene. 4. Observation on 12/1/14 at 3:20 PM showed CNA #26 performed incontinence care for resident #68. After completing the care, the CNA removed her gloves and continued to assist the resident. The CNA put a clean incontinence pad on the resident, assisted with dressing and then transferred the resident from the bed with the use of a lift. The CNA did not perform hand hygiene after removing her gloves and before continuing with other tasks. 5. Observation on 12/3/14 at 9:15 PM showed CNA #11 transferred resident #86 in a sit-to-stand lift from his/her wheelchair to the toilet. The CNA removed the resident's brief, which was wet with urine, and did not remove her gloves before lowering the resident to the toilet by using the hand controls on the lift. The CNA removed her gloves but did not perform hand hygiene before performing mouth care for the resident. CNA #11 then donned new gloves, raised the resident in the lift, wiped the resident's perineum, did not remove her gloves, and proceeded to place a	F 441		

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GOSHEN HEALTHCARE COMMUNITY	2009 LARAMIE STREET TORRINGTON, WY 82240

(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 39 new brief. The CNA removed her gloves, but did not perform hand hygiene, and transferred the resident from the bathroom to the bed. The CNA then performed hand hygiene. Interview with CNA #11 on 12/3/14 at 9:45 PM revealed she was nervous and forgot to perform adequate hand hygiene. 6. Observation on 12/2/14 at 10:11 AM showed CNA #12 took resident #4 to the toilet. After donning gloves, the CNA removed the resident's incontinence brief, stating the resident had been incontinent. After the resident voided in the toilet, the CNA cleansed the resident's perineum with a wipe. Keeping the same gloves on, the CNA then placed a clean incontinence brief on the resident, pulled up the resident's pants, helped the resident sit back down in the wheelchair, helped the resident to wash his/her hands, and pushed the resident out of the bathroom in his/her wheelchair. After the resident was out of the bathroom, the CNA removed her gloves and performed hand hygiene. 7. Review of the policy and procedure entitled, "Handwashing/Hygiene" last revised August 2014, showed "Employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions:...c. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice)...g. Before and after assisting a resident with meals...h. Before and after assisting a resident with personal care (e.g. oral care, bathing)...n. Before and after assisting a resident with toileting...u. After removing gloves or aprons..." Further, the policy showed, "Hand hygiene is always the final step after removing and	F 441		

11/8/15

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53A049	A. BUILDING _____ B. WING _____	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOSHEN HEALTHCARE COMMUNITY	2008 LARAMIE STREET TORRINGTON, WY 82240

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F 441	Continued From page 40 disposing of personal protective equipment." 8. During an interview with the DON on 12/4/14 beginning at 1 PM, she acknowledged staff needed to wash their hands after removing gloves, between residents, and after providing personal care to residents. Further, the sling used during the lift transfer should not have been available for use after it had placed on the floor.	F 441	**F498 Nurse Aide Demonstrate Competency/Care Needs** **Corrective Actions:** CNA's have been assessed to be competent in resident care using mechanical lifts and while providing pericare, by return demonstration, including CNA's #7, #26, and #27.	1/10/2015
F 498 SS=E	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on review of personnel files, and staff interview, the facility failed to ensure 3 CNAs (#7, #26, #27) observed providing less than optimal care had been evaluated for demonstrated competency in skills and techniques. The findings were: Review of the CNA education files showed those hired within in the past 4 months had a documented competency in skills checklist completed. The competency check list covered a variety of care skills including mechanical lift transfers and perineal care. The following concerns were identified: a. CNAs #7, #26, and #27 were observed to provide care which did not demonstrate competency with mechanical lift transfers and/or	F 498	**Others Potentially Affected:** All residents have the potential to be affected by this practice. **Systemic Changes:** • The DNS/designee will re-educated Certified Nursing Assistants on transfers using a mechanical lift device by 01/28/15. • The Unit Managers/designee will complete Mechanical Lift Competencies for all Certified Nursing Assistants by ~~01/28/15~~, and annually thereafter. • The DNS/designee will re-educate the CNA's on the practice of providing pericare on the residents. • The CNA's will perform a Pericare Competency and successfully perform pericare on a dependent resident. • The Licensed Nurses will be re-educated on the supervisory role of monitoring CNA's during resident care.	1/18/15

1/7/15

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

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F 498	Continued From page 41 perineal care. b. Interview with the DON on 12/3/14 at 4:25 PM revealed CNAs who had worked at the facility prior to new ownership (4 months earlier) did not have any documentation showing demonstrated competency in skills and techniques. Review of CNAs files for CNA #7, CNA #26 and CNA #27 showed they were hired prior to the change of ownership. CNA #7 was hired on 6/23/01; CNA #26 was hired on 4/20/79; and CNA #27 was hired on 1/21/88.	F 498	**Monitoring:** The DNS/designee will audit resident pericare on 8 random residents each week x 4 weeks, then monthly x 3 months, and then quarterly. **QA:** The DNS will report audit data quarterly to the Quality Assurance Committee. The Quality Assurance Committee members will analyze the results of audits to determine further corrective action if necessary to ensure continued compliance with this plan of correction or and/or termination of monitoring if intervention(s) are successful.	

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