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Healthcare Licensing and Surveys

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 01/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted at Cheyenne Health Care Center on 1/2/15. The survey was prompted by complaint intakes WY00001960, WY00001963, WY00001965, WY00001966 and WY00001968. The following common abbreviations are used throughout this document: ADLs - Activities of Daily Living CNA- Certified Nurse Aide DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set SBAR- Situation Background Assessment/Appearance Request Less commonly used abbreviations will be annotated in each deficiency.	F 000	2/9/15 Cheyenne Health Care Center-Complaint Survey – 1/2/15 – Plan of Corrections Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. This plan of correction serves as the facility's allegation of compliance.	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR 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 and staff and resident interview, the facility failed to ensure there was a sufficient number of staff members to provide the needed personal care for 10 non-sample residents (#17, #19, #20, #38, #45, #62, #74, #81, #91, #92). The findings were:	F 312	F312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CORRECTIVE ACTION Resident #17 was bathed on/before the date of compliance. Resident #19 was bathed on/before the date of compliance. Resident #20 was bathed on/before the date of compliance. Resident #38 was bathed on/before the date of compliance. Resident #45 was bathed on/before the date of compliance. Resident #62 was bathed on/before the date of compliance. Resident #74 was bathed on/before the date of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — NHA — (X6) DATE 2/11/15

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. POC accepted. DOC - 2/9/15. Message left for Jana Stewart, NHA on 2/10/15 @ 9am. Janelle Colin, ORL/C

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F 312	Continued From page 1 1. Interview with RN #3 on 1/2/15 at 6:35 PM revealed she believed the facility was short staffed which negatively impacted resident care. Interview with LPNs #1 and #2 on 1/2/15 at 6:40 PM revealed they felt the facility was understaffed and were concerned about the negative impact on resident care. During this interview, the LPNs also stated no showers had been provided on that day (1/2/15) because there was not enough staff to assist with showers. Interview with resident #8 on 1/2/14 at 8:40 PM revealed s/he thought there were not enough CNAs to meet the needs of residents and frequently s/he had to wait for care. Finally, interview with the DON on 1/2/14 at 9:31 PM revealed the facility had identified the staffing shortage through their quality assurance and performance improvement committee back in October 2014. She said the facility had been actively recruiting staff and had recently hired staff who were still being oriented. However, at this time staffing was "tight". Evidence of the failure to provide scheduled bathing: 1. Review of the 12/27/13 initial MDS assessment showed resident #17 had diagnoses including chronic obstructive pulmonary disease (COPD), respiratory failure, depression, anxiety and diabetes mellitus. Review of this MDS assessment showed the resident required extensive assistance of one for bathing and personal hygiene. Further, review of the 12/30/14 initial MDS assessment showed the resident continued to require extensive assistance of one staff for personal cares. Review of the 12/30/14 MDS assessment showed over the entire 7 day look back period the resident received no shower	F 312	Resident #81 was bathed on/before the date of compliance. Resident #91 was bathed on/before the date of compliance. Resident #92 was bathed on/before the date of compliance. **IDENTIFICATION OF OTHERS** The Director of Nursing/designee will conduct a review of all residents in the home for baths/showers/bed baths given in the past 7 days. For any residents discovered to not have received a bath in the prior 7 days the home will offer a bath/shower in accordance with their bathing schedules. For any resident that refuses bathing services; staff members are instructed to re-approach the resident to establish a better time for bathing. **SYSTEMIC CHANGES** The facility has established a bath aide program to be the primary driver for the bathing process. The IDT will audit bathing schedules and care tracker documentation daily at the morning meeting (M-F) and again at stand-down to ensure that scheduled baths/showers were completed. The DON/designee will identify of any baths/showers not completed as scheduled, will then investigate the root cause and report back to the IDT. Education of staff members regarding the bathing process will be completed on or before the date of compliance by the Staff Development Coordinator/Designee. **MONITORING**	

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F 312	Continued From page 2 or bathing. Review showed no evidence the resident refused care during that period. 2. Review of the 10/15/14 initial MDS assessment showed resident #19 had diagnoses including COPD, hypertension and non-Alzheimer's dementia. Further review of the MDS assessment showed the resident was frequently incontinent of bowel and bladder and was totally dependent upon staff for bathing and personal hygiene. Review of the 12/29/14 quarterly MDS assessment showed the resident had severe cognitive impairment and required extensive assistance with personal cares. Review of the 12/29/14 MDS assessment showed over the entire 7 day look back period the resident received no shower or bathing. Review showed no evidence the resident refused care during that period. 3. Review of the 9/2/14 significant change MDS assessment showed resident #20 had diagnoses including diabetes mellitus and non-Alzheimer's dementia. Further review of the MDS assessment showed the resident was totally dependent upon staff for bathing and personal hygiene. Review of the 11/14/14 quarterly MDS assessment showed the resident had severe cognitive impairment and continued to require extensive assistance of one staff for personal cares. Review of the 11/14/14 MDS assessment showed over the entire 7 day look back period the resident received no shower or bathing. Review showed no evidence the resident refused care during that period. 4. Review of the 12/31/14 quarterly MDS assessment showed resident #38 had diagnoses including non-Alzheimer's dementia and history of CVA (stroke). Further review of the MDS	F 312	Results of the bathing audits will be tracked and trended by the NHA/designee. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. **Date – 2/9/15**	

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F 312	Continued From page 3	F 312		

assessment showed the resident was occasionally incontinent of bowel and bladder and required extensive assistance of one for personal cares. Review of the MDS assessment showed over the entire 7 day look back period the resident received no shower or bathing. Review showed no evidence the resident refused care during that period.

5. Review of the 10/8/14 quarterly MDS assessment showed resident #45 had diagnoses including diabetes mellitus and Alzheimer's disease. Continued review of the MDS assessment showed the resident had severe cognitive impairment, was frequently incontinent of bladder and occasionally incontinent of bowel. Review showed the resident was totally dependent upon staff for bathing and personal hygiene. Review of the 12/4/14 quarterly MDS assessment showed the resident continued to require extensive assistance for personal cares. Review of the 12/4/14 MDS assessment showed over the entire 7 day look back period the resident received no shower or bathing. Review showed no evidence the resident refused care during that period.

6. Review of the 12/4/14 quarterly MDS assessment showed resident #62 had diagnoses including Alzheimer's disease. Further review of the MDS assessment showed the resident had severe cognitive impairment, was frequently incontinent of urine, and required extensive assistance of staff for bathing and personal hygiene. Review of this MDS assessment showed over the entire 7 day look back period the resident received no shower or bathing. Review showed no evidence the resident refused care during that period.

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F 312	Continued From page 4	F 312		

7. Review of the 10/15/14 annual MDS assessment showed resident #74 had diagnoses including diabetes mellitus and Alzheimer's disease. Further review of the MDS assessment showed the resident was frequently incontinent of bowel and bladder and was totally dependent upon staff for bathing and personal hygiene. Review of the 12/26/14 quarterly MDS assessment showed the resident had moderate cognitive impairment and continued to require extensive assistance of one staff for personal cares. Review of the 12/26/14 MDS assessment showed over the entire 7 day look back period the resident received no shower or bathing.

8. Review of the 9/29/14 quarterly MDS assessment showed resident #81 was occasionally incontinent of bladder and frequently incontinent of bowel. In addition, review showed the resident was totally dependent upon staff for bathing and personal hygiene Review of the 11/25/14 quarterly MDS assessment showed the resident had moderate cognitive impairment and continued to require extensive assistance of one staff for personal cares. Review of the 11/25/14 MDS assessment showed over the entire 7 day look back period the resident received no shower or bathing. Review showed no evidence the resident refused care during that period.

9. Review of the 9/29/14 quarterly MDS assessment showed resident #91 had diagnoses including COPD and diabetes mellitus. Further review of the MDS assessment showed the resident required extensive assistance of one for bathing and personal hygiene. Review of the 11/18/14 quarterly MDS assessment showed the resident had moderate cognitive impairment and

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F 312	Continued From page 5	F 312		

required limited assistance of one staff for personal cares. Review of the 11/18/14 MDS assessment showed over the entire 7 day look back period the resident received no shower or bathing. Review showed no evidence the resident refused care during that period.

10. Review of the 8/22/14 initial MDS assessment showed resident #92 had diagnoses including non-Alzheimer's dementia. Further review of the MDS assessment showed the resident was occasionally incontinent of bowel and required extensive assistance of one for bathing and personal hygiene. Review of the 11/12/14 re-admission initial MDS assessment showed the resident had severe cognitive impairment and required staff assistance with personal cares. Review of the 11/12/14 MDS assessment showed over the entire 7 day look back period the resident received no shower or bathing. Review showed no evidence the resident refused care during that period.

F 323 SS=G 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, medical record review, and staff interview, the facility failed to ensure

F 323

F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

CORRECTIVE ACTION
Fall interventions have been properly established for resident #8 and resident #48 to prevent falls.

IDENTIFICATION OF OTHERS
The DON/designee will conduct a facility wide audit of fall risk assessments; to assure accuracy. The Care Plan will be updated with interventions, if they are not included prior. The ADL flow sheets that the RCS (Cna's) staff members carry will

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F 323	Continued From page 6 effective supervision and/or interventions were implemented to prevent falls for 2 of 7 sample residents (#8, #48). The lack of timely and effective supervision resulted in harm for resident #48. The findings were: 1. Review of the medical record showed resident #48 was admitted to the facility on 2/12/13 with diagnoses including chronic obstructive pulmonary disease and muscle weakness. Review of the 9/15/14 significant change and the 11/19/14 quarterly MDS assessments showed the resident required extensive assistance of one to two staff for all ADLs including mobility. The assessments also showed the resident had impaired mobility in both the upper and lower extremity on one side. Review of the 9/26/14 and 12/28/14 fall risk evaluations showed the resident was a high fall risk. Review of the 11/20/14 (untimed) SBAR report showed the resident rolled out of the bed because of the slick surface of the mattress and the resident's increased confusion. Review of the 12/26/14 (untimed) SBAR report showed the resident was found on the floor next to the bed. Further review of the report showed the "Res [resident] attempted to get out of bed and hit [his/her] head on [the] night stand and fell to [the] floor landing on [the] padded floor mat on [the] resident['s] right side...Brief [was] saturated of urine." The resident sustained a laceration to the right side of the head. Further review of this report showed the resident called out for assistance and the tabs alarm was sounding when s/he was found on the floor. The following concerns were identified: a. Interview with LPNs #1 and #2 on 1/2/15 at 6:40 PM revealed the resident's laceration required twelve staples to close the wound. They further stated they felt the facility was	F 323	reflect the updated interventions from the care plans. The audit will occur on/before the date of compliance. The Resident Care Management Director/designee will audit all of the facility care plans for residents that are identified as a fall risk. The audit will verify that a care plan accurately reflects the residents fall risk/status. The audit will occur on/before the date of compliance. **SYSTEMIC CHANGES** Education to staff members will be provided on or before the date of compliance in regard to proper reporting of falls by the DON/Designee. Communication of interventions for falls will be included on the cardex/block sheet forms that the Resident Care Specialists (RCS, similar term for C.N.A.) carry with them. These forms will be available for staff members to update digitally as resident needs change. Education of licensed staff members regarding the fall process will be completed on or before the date of compliance by the DON/Designee. Education will be delivered to the IDT by the NHA/Designee regarding the importance of timely interventions for falls on or before the date of compliance. An audit will be completed weekly for 4 weeks of 10 random residents for fall intervention accuracy as reflected in the resident care plan by the DON/designee.	

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F 323	Continued From page 7 understaffed on the shift of the fall and this lack of sufficient staff contributed to the cause of the resident's fall. b. Observation on 1/2/14 at 8:35 PM showed the resident had a low bed and a floor mat next to it. However, review of the current care plan, last reviewed 9/3/14, showed no evidence the resident's fall risk was addressed. The resident was placed on comfort care on 4/10/14 for which a care plan was developed; fall risk and preventive measures were not included. 2. Review of the medical record showed resident #8 was admitted to the facility on 2/12/13 with diagnoses including cerebral palsy, COPD, convulsions, and a history of falls. Review of the 11/5/14 quarterly MDS assessment showed the resident required limited assistance of one with transfers and locomotion. Review also showed the resident required extensive assistance of one with toileting and personal hygiene. Review of the 10/6/14 fall risk assessment showed the resident was at high risk of falling. Review of the SBAR report showed the resident had an unwitnessed fall at 9:50 PM on 12/10/14. Review of the post fall evaluation showed the resident got out of the wheel chair and squatted down to plug the electric wheel chair in and fell in the process. Review of the SBAR showed the resident had another fall on 12/20/14 at 8:35 AM and injured his/her right shoulder. Review of the post fall evaluation showed the resident leaned forward in the wheel chair and reached down to unplug his/her electric wheel chair and fell. The resident hit the right shoulder on the dresser during the fall. Upon nursing assessment the resident had pain and limited range of motion in his/her right shoulder. Review of the care plan, last reviewed on 11/20/14, showed interventions included	F 323	**MONITORING** Results of the audits for care plan accuracy and fall interventions will be tacked and trended by the NHA/designee and reported to the QAPI committee monthly. The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. **Date** 2/9/15	

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F 323	Continued From page 8	F 323		

encouraging the resident to call for assistance to prevent falls. Interview with the resident on 1/2/15 at 8:40 PM revealed the resident was aware s/he was to ask for assistance with his/her needs. The resident further stated s/he had turned on the call light to ask for assistance but the call light went unanswered for more than 30 minutes and s/he could not wait any longer. The resident stated this was the case in both falls; s/he said the facility did not have enough CNA staff to care for resident needs in a timely manner. Review of the 11/5/14 quarterly MDS assessment showed the resident had a BIMS score of 15 out of 15 which indicates s/he was cognitively intact.

F 353 SS=E 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS

The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

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.

F 353

F353 SUFFICIENT 24-HOUR NURSING STAFF PER CARE PLANS

CORRECTIVE ACTION

The facility has initiated an Performance Improvement Plan for staffing.
The facility has developed a Critical Staffing Plan to inform staff members what are the minimum levels of staffing for the home. This Critical Staffing Plan assists staff members in knowing when they need to reach out to the facility managers for greater assistance.
The home has a goal of adding a second Unit Manager to break up the current load of the only Unit Manager to allow for

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F 353	Continued From page 9	F 353		

This REQUIREMENT is not met as evidenced by:
Based on medical record review, resident and staff interview, and review of fall documentation, the facility failed to ensure there was a sufficient number of staff members to provide the needed care for 2 of 7 sample residents (#8, #48) and for an additional 10 non-sample residents (#17, #19, #20, #38, #45, #62, #74, #81, #91, #92). The findings were:

1. Review of the medical record showed resident #48 was admitted to the facility on 2/12/13 with diagnoses including chronic obstructive pulmonary disease (COPD) and muscle weakness. Review of the 9/15/14 significant change and the 11/19/14 quarterly MDS assessments showed the resident required extensive assistance of one to two staff for all ADLs including mobility. The assessments also showed the resident had impaired mobility in both the upper and lower extremity on one side. Review of the 9/26/14 and 12/28/14 fall risk evaluations showed the resident was a high fall risk. Review of the 11/20/14 (untimed) SBAR report showed the resident rolled out of the bed because of the slick surface of the mattress and the resident's increased confusion. Review of the 12/26/14 (untimed) SBAR report showed the resident was found on the floor next to the bed. Further review of the report showed the "Res [resident] attempted to get out of bed and hit [his/her] head on [the] night stand and fell to [the] floor landing on [the] padded floor mat on [the] resident['s] right side." "Brief [was] saturated of urine." The resident sustained a laceration to the right side of the head. Further review of this

better function at communication at both station's in the home.

IDENTIFICATION OF OTHERS
Call light audits will be conducted at varying times by the NHA/designee to determine if staff members are able to answer lights timely. These audits will occur on/before the date of compliance. The facility ambassadors will ask residents if they feel if their call lights are answered timely in manner to provide a larger sample of resident input in regard to call light response times. The review will occur on/before the date of compliance.

SYSTEMIC CHANGES
The home will continue to conduct regular staff meetings (a minimum of 3x week for 12 weeks)
Staffing meetings will review but are not limited to; review of open shifts, review of open positions, discussion of recruitment efforts and new staff hiring and orientation. The Staffing Meetings will include at a minimum, the NHA, DON/Nursing Designee, and the facility Scheduler.
For ongoing audits the home will review and compare the Monthly Schedule to the Daily Sign In Sheets to the Daily 671 Posting to the Key Factor report (time clock) The comparison of these four reports in a crosswalk will offer a review of what is scheduled versus what is ~~actually worked and includes the~~

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F 353	Continued From page 10	F 353		

report showed the resident called out for assistance and the tabs alarm was sounding when s/he was found on the floor. Interview with LPNs #1 and #2 on 1/2/15 at 6:40 PM revealed the resident's laceration required twelve staples to close the wound. They further stated they felt the facility was understaffed on the shift of the fall and this lack of sufficient staff contributed to the cause of the fall.
2. Review of the medical record showed resident #8 was admitted to the facility on 2/12/13 with diagnoses including cerebral palsy, COPD, convulsions, and a history of falls. Review of the 11/5/14 quarterly MDS assessment showed the resident required limited assistance of one with transfers and locomotion. Review also showed the resident required extensive assistance of one with toileting and personal hygiene. Review of the 10/6/14 fall risk assessment showed the resident was at high risk of falling. Review of the SBAR report showed the resident had an unwitnessed fall at 9:50 PM on 12/10/14. Review of the post fall evaluation showed the resident got out of the wheel chair and squatted down to plug the electric wheel chair in and fell in the process. Review of the SBAR showed the resident had another fall on 12/20/14 at 8:35 AM and injured his/her right shoulder. Review of the post fall evaluation showed the resident leaned forward in the wheel chair and reached down to unplug his/her electric wheel chair and fell. The resident hit the right shoulder on the dresser during the fall. Upon nursing assessment the resident had pain and limited range of motion in his/her right shoulder. Review of the care plan, last reviewed on 11/20/14, showed interventions included encouraging the resident to call for assistance to prevent falls. Interview with the resident on 1/2/15 at 8:40 PM revealed the resident was aware s/he

verification of signatures on daily sign in sheets.

MONITORING

Results of the ongoing audits will be tracked and trended by the NHA/designee and reported to the QAPI committee monthly. The ongoing audits will consist of reviews of call light audits and reviews of staffing levels. The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance.

Date
2/9/15

*******ALERT********
Due to the influence of the F353 Staffing tag upon the F312 & F323 tags, I am including both of those POC's in their entirety within this tag. The information is merely provided to assist in allowing the POC for F353 to stand alone.

F312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS
CORRECTIVE ACTION

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	535025	A. BUILDING _____ B. WING _____	C 01/02/2015

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F 353	Continued From page 11 was to ask for assistance with his/her needs. The resident further stated s/he had turned on the call light to ask for assistance but the call light went unanswered for more than 30 minutes and s/he could not wait any longer. The resident stated this was the case in both falls; s/he said the facility did not have enough CNA staff to care for resident needs in a timely manner. Review of the 11/5/14 quarterly MDS assessment showed the resident had a BIMS score of 15 out of 15 which indicates s/he was cognitively intact. 3. Review of the 12/27/13 initial MDS assessment showed resident #17 had diagnoses including COPD, respiratory failure, depression, anxiety and diabetes mellitus. Further review of the MDS assessment showed the resident required extensive assistance of one for bathing and personal hygiene. Review of the 12/30/14 initial MDS assessment showed the resident continued to require extensive assistance of one staff for personal cares. Review of the 12/30/14 MDS assessment showed over the entire 7 day look back period the resident received no shower or bathing. Review showed no evidence the resident refused care during that period. 4. Review of the 10/15/14 initial MDS assessment showed resident #19 had diagnoses including COPD, hypertension and non-Alzheimer's dementia. Further review of the MDS assessment showed the resident was totally dependent upon staff for bathing and personal hygiene. Review of the 12/29/14 quarterly MDS assessment showed the resident had severe cognitive impairment and required extensive assistance with personal cares. Review of the 12/29/14 MDS assessment showed over the entire 7 day look back period the resident received no shower or bathing. Review	F 353	Resident #17 was bathed on/before the date of compliance. Resident #19 was bathed on/before the date of compliance. Resident #20 was bathed on/before the date of compliance. Resident #38 was bathed on/before the date of compliance. Resident #45 was bathed on/before the date of compliance. Resident #62 was bathed on/before the date of compliance. Resident #74 was bathed on/before the date of compliance. Resident #81 was bathed on/before the date of compliance. Resident #91 was bathed on/before the date of compliance. Resident #92 was bathed on/before the date of compliance. **IDENTIFICATION OF OTHERS** The Director of Nursing/designee will conduct a review of all residents in the home for baths/showers/bed baths given in the past 7 days. For any residents discovered to not have received a bath in the prior 7 days the home will offer a bath/shower in accordance with their bathing schedules. For any resident that refuses bathing services; staff members are instructed to re-approach the resident to establish a better time for bathing. **SYSTEMIC CHANGES** The facility has established a bath aide program to be the primary driver for the bathing process.	

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F 353	Continued From page 12 showed no evidence the resident refused care during that period. 5. Review of the 9/2/14 significant change MDS assessment showed resident #20 had diagnoses including diabetes mellitus and non-Alzheimer's dementia. Further review of the MDS assessment showed the resident was totally dependent upon staff for bathing and personal hygiene. Review of the 11/14/14 quarterly MDS assessment showed the resident had severe cognitive impairment and continued to require extensive assistance of one staff for personal cares. Review of the 11/14/14 MDS assessment showed over the entire 7 day look back period the resident received no shower or bathing. Review showed no evidence the resident refused care during that period. 6. Review of the 12/31/14 quarterly MDS assessment showed resident #38 had diagnoses including non-Alzheimer's dementia and history of CVA (stroke). Further review of the MDS assessment showed the resident required extensive assistance of one for personal cares. Review of the MDS assessment showed over the entire 7 day look back period the resident received no shower or bathing. Review showed no evidence the resident refused care during that period. 7. Review of the 10/8/14 quarterly MDS assessment showed resident #45 had diagnoses including diabetes mellitus and Alzheimer's disease. Further review of the MDS assessment showed the resident had severe cognitive impairment and was totally dependent upon staff for bathing and personal hygiene. Review of the 12/4/14 quarterly MDS assessment showed the resident continued to require extensive	F 353	The IDT will audit bathing schedules and care tracker documentation daily at the morning meeting (M-F) and again at stand-down to ensure that scheduled baths/showers were completed. The DON/designee will identify of any baths/showers not completed as scheduled, will then investigate the root cause and report back to the IDT. Education of staff members regarding the bathing process will be completed on or before the date of compliance by the Staff Development Coordinator/Designee. **MONITORING** Results of the bathing audits will be tracked and trended by the NHA/designee. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. **Date – 2/9/15** **F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** **CORRECTIVE ACTION** Fall interventions have been properly established for resident #8 and resident #18 to prevent falls.	

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F 353	Continued From page 13 assistance for personal cares. Review of the 12/4/14 MDS assessment showed over the entire 7 day look back period the resident received no shower or bathing. Review showed no evidence the resident refused care during that period. 8. Review of the 12/4/14 quarterly MDS assessment showed resident #62 had diagnoses including Alzheimer's disease. Further review of the MDS assessment showed the resident had severe cognitive impairment and required extensive assistance of staff for bathing and personal hygiene. Review of this MDS assessment showed over the entire 7 day look back period the resident received no shower or bathing. Review showed no evidence the resident refused care during that period. 9. Review of the 10/15/14 annual MDS assessment showed resident #74 had diagnoses including diabetes mellitus and Alzheimer's disease. Further review of the MDS assessment showed the resident was totally dependent upon staff for bathing and personal hygiene. Review of the 12/26/14 quarterly MDS assessment showed the resident had moderate cognitive impairment and continued to require extensive assistance of one staff for personal cares. Review of the 12/26/14 MDS assessment showed over the entire 7 day look back period the resident received no shower or bathing. 10. Review of the 9/29/14 quarterly MDS assessment showed resident #81 was totally dependent upon staff for bathing and personal hygiene. Review of the 11/25/14 quarterly MDS assessment showed the resident had moderate cognitive impairment and continued to require extensive assistance of one staff for personal	F 353	**IDENTIFICATION OF OTHERS** The DON/designee will conduct a facility wide audit of fall risk assessments; to assure accuracy. The Care Plan will be updated with interventions, if they are not included prior. The ADL flow sheets that the RCS (Cna's) staff members carry will reflect the updated interventions from the care plans. The audit will occur on/before the date of compliance. The Resident Care Management Director/designee will audit all of the facility care plans for residents that are identified as a fall risk. The audit will verify that a care plan accurately reflects the residents fall risk/status. The audit will occur on/before the date of compliance. **SYSTEMIC CHANGES** Education to staff members will be provided on or before the date of compliance in regard to proper reporting of falls by the DON/Designee. Communication of interventions for falls will be included on the cardex/block sheet forms that the Resident Care Specialists (RCS, similar term for C.N.A.) carry with them. These forms will be available for staff members to update digitally as resident needs change. Education of licensed staff members regarding the fall process will be completed on or before the date of compliance by the DON/Designee. Education will be delivered to the IDT by the NHA/Designee regarding the	

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F 353	Continued From page 14 cares. Review of the 11/25/14 MDS assessment showed over the entire 7 day look back period the resident received no shower or bathing. Review showed no evidence the resident refused care during that period. 11. Review of the 9/29/14 quarterly MDS assessment showed resident #91 had diagnoses including COPD and diabetes mellitus. Further review of the MDS assessment showed the resident required extensive assistance of one for bathing and personal hygiene. Review of the 11/18/14 quarterly MDS assessment showed the resident had moderate cognitive impairment and required limited assistance of one staff for personal cares. Review of the 11/18/14 MDS assessment showed over the entire 7 day look back period the resident received no shower or bathing. Review showed no evidence the resident refused care during that period. 12. Review of the 8/22/14 initial MDS assessment showed resident #92 had diagnoses including non-Alzheimer's dementia. Further review of the MDS assessment showed the resident required extensive assistance of one for bathing and personal hygiene. Review of the 11/12/14 re-admission initial MDS assessment showed the resident had severe cognitive impairment and required staff assistance with personal cares. Review of the 11/12/14 MDS assessment showed over the entire 7 day look back period the resident received no shower or bathing. Review showed no evidence the resident refused care during that period. 13. Interview with RN #3 on 1/2/14 at 6:35 PM revealed she believed the facility was short staffed which negatively impacted resident care.	F 353	importance of timely interventions for falls on or before the date of compliance. An audit will be completed weekly for 4 weeks of 10 random residents for fall intervention accuracy as reflected in the resident care plan by the DON/designee. **MONITORING** Results of the audits for care plan accuracy and fall interventions will be tacked and trended by the NHA/designee and reported to the QAPI committee monthly. The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. **Date** 2/9/15	

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F 353	Continued From page 15 Interview with LPNs #1 and #2 on 1/2/15 at 6:40 PM revealed they felt the facility was understaffed and were concerned about the negative impact on resident care. Interview with resident #8 on 1/2/14 at 8:40 PM revealed s/he thought there were not enough CNAs to meet the needs of residents and frequently s/he had to wait for care. Finally, interview with the DON on 1/2/14 at 9:31 PM revealed the facility had identified the staffing shortage through their quality assurance and performance improvement committee back in October 2014. She said the facility had been actively recruiting staff and had recently hired staff who were still being oriented. However, at this time staffing was "tight".			
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 353	F520 Quality Assurance/Performance Improvement **Corrective Action** The current staffing plan has been implemented. It has been reviewed by the new NHA(start date 1/20/15) and Division Director of Clinical Services. **ID of Others** Quality Assurance affects all residents. The home will review past PIP's and Action Plans from the past 60 days of Quality Assurance coverage. Each plan will be reviewed by the NHA for current effectiveness and will include a verification of systems still in place. The NHA will conduct this review on/before the date of compliance. **Systemic Change** Education was provided to the IDT by the NHA on 1/22/15 in regard to the workings of an efficient QAPI program. The information presented will be a reflection of the CMS training: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-05.pdf **Monitoring** – Weekly QAPI meetings will be held for the following 12 weeks	
F 520				

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F 520	Continued From page 16 Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and review of medical records and fall documents, the facility failed to ensure the quality assurance and performance improvement (QAPI) program was timely in implementing interventions to resolve an identified problem with staffing. The findings were: Interview with the DON on 1/2/14 at 9:31 PM revealed the facility QAPI team had identified insufficient staffing as a problem in October 2014. However, interventions were not implemented until 1/2/15; three months after identification of the problem. Investigation of five complaints on 1/2/15 resulted in citation of deficient practice for F312 (personal care and grooming for the dependent resident), F323 (failure to prevent falls), and F353 (staffing).	F 520	from the date of 1/21/15 through 4/15/15. Those meetings will review the overall events of the building including, but not limited to, the resulting deficiencies from the 1/2/15 Survey. The focus of the weekly QAPI meetings is to establish a flow and execution to plans and delivery. As appropriate the home will involve Senior Leadership for guidance. Each month the home will have a larger QAPI meeting, resulting in 3 weekly and 1 full QAPI each month. The home will continue this practice for 3 months resulting in 12 weeks of QAPI weekly with 3 larger full meetings and 9 smaller weekly meetings focused on the current survey resolution. The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. **Date** 2/9/15	