STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535053	A. BUILDING _____ B. WING _____	C 01/23/2015

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PLATTE COUNTY MEMORIAL NURSING HOME	204 15TH STREET WHEATLAND, WY 82201

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F 000	INITIAL COMMENTS A complaint survey was conducted in conjunction with the recertification survey by the Office of Healthcare Licensing and Surveys on 1/20/15 through 1/23/15. The survey was prompted by complaint intake WY00001928. 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 RN- Registered nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	This plan of correction is submitted as required under State and Federal law. This plan does not constitute admission of liability on the part of the facility and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency or that the scope or severity regarding the deficiencies cited are correctly applied.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge	F 157		

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

Administrator 2/16/15

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.

Accepted on 2/19/15 w/ changes to pg 7. Per NHA Shane Phelps. DOC = 3/16/15

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

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F 157	Continued From page 1 the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to notify the physician of a change in condition for 1 of 4 sample residents (#29) with a change in condition. The findings were: Observation on 1/20/15 at 3:08 PM showed resident #29 had visible edema to the lower legs, especially on the right side, and was complaining of right leg pain. Interview with CNA #1 at that time revealed she had not previously noted edema to the resident's legs. CNA #1 was then observed to bring the edema to the attention of LPN #2. Review of medical records on 1/21/15 at 4 PM failed to reveal any communication to the resident's physician about the lower leg edema. Review of the January 2015 physician order recapitulation showed the resident did not have	F 157	F157- Dr. Palmer was notified of Resident #29's bilateral pedal on 2/9/15 with no new orders or changes in treatment recommended at this time. Nursing staff will be re-educated on assessing our residents for changes in condition and promptly reporting changes in condition to the physician at the 2/17/15 all staff meeting. Facility will have a current assessment reference book on hand for nursing staff to review assessment techniques. Current physician communication systems will be reviewed with nursing staff when it is appropriate to call, when to have the resident seen at the clinic and when to send an SBAR communication form. DON and/or designee will listen to the nurses taped shift report weekly using an auditing tool and follow up on any residents with changes in condition to ensure the physician notification process is followed. Audits will be weekly x 3 months and monthly thereafter. DON and/or designee will report findings to QA&A for further review and analysis.	3/6/15

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F 157	Continued From page 2 orders for a diuretic. Interview with LPN #3 on 1/21/15 at 8:37 PM revealed the resident's lower leg edema had been noted by staff "over the last couple of weeks." The LPN further revealed the resident's physician had not been contacted about the edema, stating "we haven't really addressed it yet."	F 157		
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, medical record review and resident and staff interview, the facility failed to maintain the dignity of 2 of 9 sample residents (#21, #29). The findings were: 1. Review of the 12/22/14 quarterly MDS assessment for resident #29 showed the resident was frequently incontinent. Review of the resident's care plan, updated on 12/26/14, revealed the resident was "able to make it to the bathroom in time if somebody helps me." Further review of the care plan revealed interventions included "I need limited assist with transfers, walking in room and using the toilet" and "answer my call light promptly and help me to the bathroom quickly when I ask." Interview with CNA #3 on 1/21/15 at 7:50 PM revealed the call light for the resident's room had been activated at that time. The following concerns were identified:	F 241	F241- Resident #29 has been moved to a room across from the nurses' station to allow for improved visualization of needs and improved access to the bathroom. Care plan has been reviewed and updated to ensure resident's toileting needs are being met. Resident #21 will be cleanly shaven and appear clean and neat looking as indicated in their plan of care. Staff will be re-educated on resident dignity at the 2/17/15 all staff meeting. DON or designee will audit residents to ensure a neat and clean appearance daily using auditing tool for 3 months and weekly thereafter. Dignity concerns will be reported to DON who will investigate patterns and report to QA.	3/6/15

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F 241	Continued From page 3 a. Observation of the resident at 7:58 PM revealed the resident was seated on the side of his/her bed. Interview of the resident at that time revealed the resident needed to use the toilet, but s/he was unable to because the door was locked and s/he couldn't "get in there." b. Observation at 8:08 PM showed the resident got up from the bed, ambulated with a walker to the bathroom door, and attempted to open it. Unable to open the bathroom door, the resident returned to the bed and continued to wait for assistance. c. Observation at 8:12 PM showed LPN #4 walked by the resident's room, and entered another room. At 8:13 PM, the resident again got up from the bed, ambulated to the bathroom door and attempted to open it. Again unsuccessful, the resident returned to the bed. LPN #4 passed by the resident's room again at 8:16 PM. d. At 8:21 PM the resident was observed to ambulate out of his/her room into the hallway. The resident was visibly upset at this time, stating "It's been so long. I changed it and everything is all wet." LPN #3 came from the nurses station to assist the resident, and interview with the LPN at that time confirmed the resident's bed was wet. Observation of the computer monitor at the nurses' station, which displayed active call lights, beginning at 7:55 PM revealed the resident's call light remained activated until LPN #3 assisted the resident, a period of 31 minutes. 2. Medical record review revealed resident #21 had a care plan, with an onset date of 12/13/13 which showed the resident had dementia related to a history of alcoholism. Further review showed the resident "will be kept clean and neat looking" and staff will "set up hygiene supplies to help me brush my teeth, hair, wash my face, and shave."	F 241		

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F 241	Continued From page 4 Observation on 1/20/15 at 2:24 PM showed the resident was ambulating in the hall without an assistive device. The resident had a dirty appearance, was unshaven, had nasal discharge, and food particles stuck in his/her facial hair. Continued observation showed the resident had a dark area on the back of his/her pants that appeared to be wet. At that time CNA #2 saw the resident ambulating and obtained a walker for the resident, but did not offer to assist the resident with hygiene needs. Observation on 1/20/15 at 4:20 PM showed the resident remained in the un-groomed state while sitting in a common area sleeping.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to accommodate resident needs for 1 of 9 sample residents (#29). The findings were: Review of the 12/22/14 quarterly MDS assessment for resident #29 showed the resident was frequently incontinent of bladder and bowel. Review of the resident's care plan for incontinence, updated on 12/26/14, revealed the	F 246	F246- Resident #29 has been moved to a room across from the nurses' station to allow for improved visualization of needs and improved access to the bathroom. Residents including #29 will be assessed for bladder control concerns and potential for toileting program. Care plan will be revised if needed to further accommodate their incontinence needs. All locks will be removed from bathroom doors to ensure residents have access to the bathroom. Staff has been re-educated regarding call light response times. Management staff including but not limited to; DON, ADON and Social Service Manager will carry pagers while on duty with	3/6/15

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F 246	Continued From page 5 resident was "able to make it to the bathroom in time if somebody helps me." Interventions included "I need limited assist with transfers, walking in room and using the toilet" and "answer my call light promptly and help me to the bathroom quickly when I ask." An update to the care plan for nutrition issues dated 1/13/15 revealed the resident had fallen while trying to get into the bathroom. The following concerns were identified: a. Observation of the resident on 1/21/15 at 7:58 PM revealed the resident was seated on the side of his/her bed. Interview of the resident at that time revealed the resident needed to use the toilet, but s/he was unable to because the bathroom door was locked and s/he couldn't "get in there." b. Interview with CNA #3 on 1/21/15 at 7:50 PM revealed the resident's call light had been activated at that time. Observation of the computer monitor at the nurse's desk showed the call light remained activated until 8:21 PM (31 minutes). c. Observation at 8:08 PM showed the resident got up from the bed, ambulated with a walker to the bathroom door, and attempted to open it. Unable to open the bathroom door, the resident returned to the bed and continued to wait for assistance. d. Observation at 8:13 PM showed the resident again got up from the bed, ambulated to the bathroom door and attempted to open it. Again unsuccessful, the resident returned to the bed. e. At 8:21 PM the resident was observed to ambulate out of his/her room into the hallway. The resident was visibly upset at this time, stating "It's been so long. I changed it and everything is all wet." Interview with LPN #3 at that time	F 246	notification of call lights still on at 15 minutes. DON and/or designee will review call light logs for call lights > 20 minutes while out of the building (after hours and on weekends). Follow up with staff will take place when call light response times exceeds these limits. An audit will be conducted by Maintenance or designee to ensure that resident bathrooms are easily accessible. Maintenance or designee will audit all resident bathrooms monthly times 3 months and quarterly thereafter to ensure resident bathrooms are easily accessible. All results will be taken to QA&A for further review and analysis.	

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F 246	Continued From page 6 confirmed the resident's bed was wet. The LPN further revealed that the resident was frequently locked out of his/her bathroom. f. Review of nursing notes dated 1/21/15, timed 9:14 PM, revealed "...Resident requested assistance to bathroom, as other resident had locked the door, a common appearance [sic]..." g. Interview with the DON on 1/23/15 at 1:15 PM revealed the facility had not attempted any solutions to the issue of the frequently locked bathroom door.	F 246		
F 309 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, resident interview and review of policy and procedure, the facility failed to ensure neurological assessments were completed as necessary for 6 of 9 sample residents (#4, #9, #11, #12, #21, #29) who experienced falls. In addition, the facility failed to ensure the apical pulse was assessed prior to medication administration of Digoxin for 2 of 2 sample residents (#11, #30) who used this medication. The findings were: 1. Policy and Procedure review for "Fall Risk"	F 309	F309- Nursing staff will be re-educated on the necessity of neurological assessments after a fall and the facility policy relating to neurological assessments. Education will take place at the 2/17/15 all staff meeting and by one on one education with nursing staff 2/16/15 through 3/6/15. The fall team will audit all falls at the weekly fall review meetings to ensure compliance with the policy recommendations. DON and/or designee will audit documentation of falls after each fall to ensure compliance with the fall policy assessment recommendations including neurological assessments. Any deviation from the policy will be immediately brought to the nurse's attention via either one on one re-education or telephone re-education. Compliance rate will be assessed monthly and brought to QA meetings for further review and analysis.	3/6/15 for all residents including #4, #9, #11, #12, #21, #29. Change per phone NHA on 2/19/15

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F 309	Continued From page 7 revised on 6/18/14 showed the nurse on duty will assess for injury by performing physical assessment for all falls. Further review revealed neurological (neuro) checks should be performed "on all potential head injury or unwitnessed falls at the time of the fall, Q [every] 15 min x 4, Q [every] 30 min x 2, Q [every] 2 hrs x 1, and Q [every] 4 hrs x 2 using the neurological assessment flow sheet." The following resident falls were identified without the neurological assessments completed: a. Review of nurse's notes dated 12/31/14 timed 7:59 PM showed resident #11 had a fall with head injury. The nurse documented the resident had a scalp wound, and a small "goose egg" on the left area of the skull. The physician and family were notified and family wished to have the resident observed and monitored overnight. In addition, the note showed the resident was assessed and vital signs were taken. Further review of nurse's notes showed the next note was made on 1/1/15 at 4:04 AM. The note showed vital signs (VS) were taken at 1:48 AM and were within normal limits, further the note showed the nurse "viewed wound to back of head and found size to be consistent." Review of the 12/31/14 and the January 2015 nurses' notes and review of the medical record failed to show neuro checks/assessments were completed. Interview with the DON on 1/21/15 at 4:45 PM verified she was unable to locate any neuro checks/assessment related to this fall with head injury. b. Review of nurse's notes showed resident #12 had an unwitnessed fall on 1/12/15. Review of the 1/12/15 timed at 9:43 PM note showed it was a "late entry" and the resident was found on the floor in his/her room "at around 1930 [7:30 PM]." According to the note, the resident stated s/he was attempting to self transfer and lost	F 309	Nursing staff will be re-educated on the requirement for an apical pulse and parameters for administration prior to administering Digoxin for all residents including residents #11 and #30. Medication administration records will be reviewed for any medications with special requirements by DON or designee and pharmacist by medication reconciliation on 2/26/15. Any special requirements will be added to the MAR as a reminder for nursing staff during administration of medications. EMR has been purchased and implementation of eMAR and eTAR is scheduled to take place the week of March 9th-13th. Safeguards are set up in the EMR software to ensure special requirements are met prior to medication administration. DON and/or designee will review MAR and/or medication administration reports using an auditing tool to ensure medications with special requirements are administered appropriately. Audits will be done weekly for 3 months and bi-weekly thereafter and brought to QA&A for further review and analysis.	3/6/15

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F 309	Continued From page 8 balance, further, the note showed the resident denied hitting his/her head. Continued review of the medical record showed a neuro check was completed after the fall on 1/12/15 at 9:56 PM; however, the record failed to show any additional neuro checks/assessments were completed. Interview with the DON on 1/21/15 at 3 PM verified the policy and procedure should have been followed for this resident because the fall was unwitnessed. c. Medical record review for resident #4 revealed the resident had a fall risk assessment completed on 12/10/14 with a score of 16 indicating s/he was high risk for falls. Further review showed that the resident had a fall on 1/21/15 at 1:05 AM and was found on the floor. Neuro check records received from the facility on 1/21/15 at 2:05 PM revealed that neuro checks were performed at 1:10 AM, 2:30 AM, and 2:45 AM. Interview with the DON on 1/21/15 at 2:05 PM revealed there were no neuro checks available between the initial check performed at 1:10 AM and the check performed at 2:30 AM. Continued interview also showed that no neuro checks had been documented for the day shift at that time. d. Medical Record review for resident #21 revealed the resident had a fall risk assessment completed on 12/3/14 with a score of 19 indicating s/he was high risk for falls. Further review showed the fall was not witnessed. Interview with the DON on 1/21/15 at 2:05 PM revealed neuro checks were not performed because the resident stated he did not hit his head. e. Observation on 1/20/15 at 3:08 PM showed resident #29 was found on the floor by staff. The resident stated s/he had hit his/her head during the fall, and was holding his/her hand	F 309		

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F 309	Continued From page 9 up to the left side of his/her forehead. Review of the neurological evaluation flow sheet started 1/20/15 at 3:30 PM showed the resident was assessed for changes in neurological status at 3:30 PM, 4 PM, 4:15 PM, 4:45 PM, 5:15 PM, 5:45 PM and 8:50 PM. No further neurological evaluations were recorded. Interview with the DON on 1/23/15 at 10:06 AM confirmed no further neurological assessments had been completed. Review of nursing notes showed resident also fell on 1/13/15, and hit his/her head on a bedside table. Review of the medical record failed to show evidence any neurological assessments were completed on the resident after the fall. Interview with the DON on 1/23/15 at 10:05 AM confirmed no neurological assessments had been completed after this fall. f. Review of nursing notes showed resident #9 had an unwitnessed fall on 12/2/14 at 4:36 AM. Review of the neurological evaluation flow sheet dated 12/2/14 showed a single neurological assessment was completed at 4:40 AM. Interview with the DON on 1/23/15 at 10:06 AM confirmed no further neurological assessments had been completed after this unwitnessed fall. 2. Review of the reference provided by the facility used as their standard of care showed it was from the Lippincott, Williams, and Wilkins, "Nursing 2013 Drug Handbook." This reference showed "Excessively slow pulse rate (60 beats/minute or less) may be a sign of digitalis toxicity. Withhold drug and notify prescriber." The following concerns were identified: a. Observation on 1/22/15 at 12:10 PM showed resident #30 was given Digoxin (a medication to treat certain heart conditions) 0.25 mg by mouth, with water. A pulse was not obtained by RN #1 prior to administration of the	F 309		

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F 309	Continued From page 10 medication. Review of the medical record showed there was no apical pulse recorded. Interview with the DON on 1/23/15 at 9:55 AM revealed the apical pulse should be documented on the MAR and the nurse should hold the medication if pulse is less than 60 beats per minute. b. Review of the January 2015 MAR showed resident #11 had orders for lanoxin 0.125 mg daily. The nurse documentation on the MAR from 1/1/15 to 1/21/15 related to administration of this medication showed 11 of the 21 days when there was no apical pulse recorded. c. Review of the MARs for the months of December, 2014 for resident #30 showed an order for Digoxin 0.125 mg to be given by mouth daily. Further review of the December, 2014 MAR showed a pulse rate was recorded only 7 of the 31 times the medication was administered (22.6%). Review of the January, 2015 MAR showed the month began with the same order for digoxin, and also showed the order was changed on 1/16/15 to digoxin 0.25 mg by mouth every other day, alternating with digoxin 0.125 mg by mouth. Further review of the January, 2015 MAR showed a pulse rate was recorded only 12 of the 21 times the medication was administered (57%).	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	F 315		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE COUNTY MEMORIAL NURSING HOME	204 15TH STREET WHEATLAND, WY 82201

(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 315	Continued From page 11 function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and resident and staff interview, the facility failed to provide services to maintain as much normal bladder function as possible for 1 of 6 sample residents (#29) with incontinence. The findings were: 1. Review of the admission MDS assessment dated 6/28/14 for resident #29 showed the resident was continent of bladder and occasionally incontinent of bowel. Review of the 12/22/14 quarterly MDS assessment showed the resident had become frequently incontinent of both bladder and bowel. Review of the resident's care plan, updated on 12/26/14, revealed the resident was "able to make it to the bathroom in time if somebody helps me." Further review of the care plan revealed interventions included "I need limited assist with transfers, walking in room and using the toilet" and "answer my call light promptly and help me to the bathroom quickly when I ask." The following concerns were identified: a. Interview with CNA #3 on 1/21/15 at 7:50 PM revealed the call light for the resident's room had been activated at that time. Observation of the resident at 7:58 PM revealed the resident was seated on the side of his/her bed. Interview of the resident at that time revealed the resident needed to use the toilet, but s/he was unable to because the door was locked and s/he couldn't "get in there." b. Observation at 8:08 PM showed the resident got up from the bed, ambulated with a	F 315	F315-Resident #29 has been moved to a room across from the nurses' station to allow for improved visualization of needs and improved access to the bathroom. Resident #29's care plan has been reviewed and updated. Resident #29 was started on a restorative program to strengthen pelvic floor and core muscles to attempt to improve bladder control on 2/6/15 and will be reassessed for toileting program. Staff will be educated on 2/17/15 on residents receiving the appropriate treatments and service to prevent incontinence. MDS Coordinator or designee will audit voiding roster of all residents (generated by CNAs computer documentation of toileting) to identify frequent incontinence with residents on 2/13/15. MDS Coordinator or designee will audit voiding roster of all residents weekly times 3 months and quarterly thereafter to assess for bladder program candidates. All results will be taken to QA&A for further review and analysis	3/6/15

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F 315	Continued From page 12 walker to the bathroom door, and attempted to open it. Unable to open the bathroom door, the resident returned to the bed and continued to wait for assistance. c. Observation at 8:12 PM showed LPN #4 walked by the resident's room, and entered another room. At 8:13 PM, the resident again got up from the bed, ambulated to the bathroom door and attempted to open it. Again unsuccessful, the resident returned to the bed. LPN #4 passed by the resident's room again at 8:16 PM. d. At 8:21 PM the resident was observed to ambulate out of his/her room into the hallway. The resident was visibly upset at this time, stating "It's been so long. I changed it and everything is all wet." LPN #3 came from the nurse's station to assist the resident, and interview with the LPN at that time confirmed the resident's bed was wet, and further revealed the resident was frequently locked out of the bathroom. Observation of the computer monitor at the nurses' station, which displayed active call lights, beginning at 7:55 PM revealed the resident's call light remained activated until LPN #3 assisted the resident, a period of 31 minutes. e. Review of nursing notes dated 1/21/15, timed 9:14 PM, revealed "...Resident requested assistance to bathroom, as other resident had locked the door, a common appearance [sic]..." f. Interview with the DON on 1/23/15 at 1:15 PM revealed the facility had not attempted any solutions to the issue of the frequently locked bathroom door.	F 315		
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	F 323		

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F 323	Continued From page 13 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 and staff interview, the facility failed to provide supervision to prevent falls for 1 of 9 sample residents (#40) with falls. This lack of supervision resulted in the resident sustaining rib fractures. The findings were: Review of a facility incident report dated 10/10/14 showed the resident had fallen while in the bathroom. The resident failed to use the call light when done, and fell while attempting to self-transfer. Review of the hospital discharge summary dated 10/14/14 showed resident #40 had been admitted to the hospital on 10/11/14 after experiencing vomiting and "unsteadiness and falls." The resident was found to have a right lower lung pneumonia, and was discharged back to the nursing home with orders for antibiotic treatments. Review of nursing admission notes dated 10/14/14, timed 3 PM, revealed the resident required a staff assist of 1 for toileting. The following concerns were identified: a. Review of nursing notes dated 10/20/14, timed 9 PM, showed the resident was "weak tonight and unable to walk to and from dinner. Required one person assist with transfers, toileting, ADLs and stand by for locomotion via walker." b. Review of nursing notes dated 10/21/14, timed 8:15 AM, revealed the resident had fallen,	F 323	F323- The CNA assisting resident #40 on 10/21/15 has been educated on fall risk and leaving a high risk resident unattended. Nursing staff will be educated regarding the fall policy, resident safety, and resident supervision to better prepare them for the possibility of falls in our population. Education will take place at the 2/17/15 all staff meeting and by one on one education with nursing staff 2/16/15 through 3/6/15. All nursing staff will be educated by March 6th, 2015. The care plan team will review the residents currently at risk for falls to ensure the care plan addresses the risks and interventions are in place to minimize the risk of injury related to falls. All residents will be reviewed by 3/6/15. The facility fall policy will be reviewed and revised by 2/17/15. Residents noted to have a change in condition causing a higher risk for falls will be identified by charge nurses and/or nursing staff and added to the daily shift report and communication book. Risk management team will review all residents by 3/6/15 for fall risk to ensure any at risk resident is	3/6/15

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F 323	Continued From page 14 and was complaining of pain "to left ribs." Review of nursing notes dated 10/20/14, timed 7:10 PM, showed the resident had fallen earlier in the day and had sustained a rib fracture. c. Review of a facility incident investigation of the resident's 10/21/14 fall showed the resident was being assisted in the bathroom by a CNA. The CNA assisted the resident with lowering his/her pants so the resident could stand at the toilet and urinate. The CNA then stepped out of the bathroom to speak to another resident. The resident fell a short time later, hitting his/her left side. X-rays were ordered, and "the Xray report from 10/21/14 stated 'I worry about non-displaced fractures to the 8th and 9th ribs." d. Review of nursing notes dated 10/22/14, timed 4 PM, showed the resident's nail beds and lips were cyanotic, and the resident's oxygen saturation measurement was 79%. Further review of nursing notes revealed the resident was transferred to the emergency department at 4:45 PM. Nursing notes dated 10/27/14, untimed, revealed the resident "died in acute care this AM." e. Interview with the DON on 1/23/15 at 1:15 PM revealed facility staff should not have left the resident standing in the bathroom unattended, and should have seated the resident on the toilet before leaving the room. The DON further revealed that no staff training on supervising residents in the bathroom had been offered to staff after the resident's 10/21/14 fall.	F 323	identified and care planned appropriately. Any resident sustaining a significant injury from a fall will be reviewed for cause by the Risk management team. Members of the administrative team including but not limited to DON/ADON/ MDS coordinator will perform regular weekly rounds to question floor staff about residents on "high alert" for falls. Any incorrect or unclear responses will be immediately clarified. Responses will be logged using an auditing tool and brought to QA&A for further review and analysis.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections;	F 328		

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F 328	Continued From page 15 Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to provide ordered respiratory care for 1 of 5 sample residents (#29) who had orders for supplemental oxygen. The findings were: Review of the face sheet for resident #29 showed the resident had diagnoses that included iron deficiency anemia. Review of nursing notes revealed the resident's iron deficiency anemia was treated with B12 injections and blood transfusions. Review of the January, 2015 physician order recapitulation showed the resident had an order dated 6/20/14 for supplemental oxygen to be administered via nasal cannula at a rate of 2 liters per minute to keep the resident's oxygen saturation levels greater than 90%. Review of the resident's care plan for falls and incontinence, last updated on 12/26/14, showed interventions that included "Make sure I have my oxygen on and my oxygen level is at least 90%." The following concerns were identified: a. Periodic observation of the resident from 1/20/15 through 1/22/15 showed the resident did not receive supplemental oxygen. Observation on 1/20/15 at 3:08 PM showed the resident had fallen, and staff did not offer the resident	F 328	F328- Resident #29 has been evaluated by the physician during nursing home clinic on 2/4/15. At which time the resident's oxygen usage was addressed. Resident "flatly refuses to wear oxygen" as resident discussed with facility medical director. Oxygen supplementation was discontinued and iron supplementation was ordered. . The care plan team will audit current resident respiratory care by visual inspections to ensure proper treatment. Nursing staff will be educated at the 2/17/15 all staff meeting regarding follow through, implementation and clarification of physician orders. Residents noted to have a change in condition and/or frequent refusals of treatment, will be identified by charge nurses and/or nursing staff and added to the daily shift report and communication book. Care plan will be updated as needed. DON or designee will audit respiratory care orders to ensure that they are being administered correctly weekly times 3 months and quarterly thereafter. All results will be taken to QA&A for review and analysis.	3/6/15

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F 328	Continued From page 16 supplemental oxygen, or encourage the resident to wear the nasal cannula at that time. Observation on 1/21/15 at 8:40 PM showed the resident was being assisted to bed. Staff did not offer the resident supplemental oxygen at that time, or encourage the resident to wear the nasal cannula. b. Review of the resident's medical record failed to show regular monitoring of the resident's oxygen saturation levels despite the physician order specifying the resident's oxygen saturation levels were to be kept greater than 90%. c. Review of the January, 2015 MAR showed the resident's supplemental oxygen was initialed as being administered on all three shifts on 1/20/15, 1/21/15, and 1/22/15. There was no indication the resident refused the supplemental oxygen. d. Interview with the DON on 1/23/15 at 1:15 PM confirmed oxygen saturation levels cannot be titrated without regular monitoring of the resident's oxygen saturation levels. The DON further confirmed when a resident refuses supplemental oxygen, the refusal should be documented on the MAR.	F 328		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure a sanitary environment was maintained in 1 of 2 kitchens (main kitchen). The findings were: 1. Observation on 1/20/15 at 10:35 AM showed the floor underneath the dry storage shelving near the back door, and the floor in the walk-in-freezer were in need of cleaning. Both floors required sweeping to remove bits of paper and food crumbs. Observation on 1/22/15 at 10:50 AM showed the floors remained in the un-swept condition. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 2. Observation on 1/22/15 at 10:50 AM showed plastic beverage pitchers which were stored on a shelf. Seven of these pitchers were noted to have fissures and cracks throughout the plastic which would prevent effective cleaning and sanitation. In addition, on the same shelf there were two cutting boards which were discolored and scored, unable to be effectively cleaned and sanitized. According to Food Code 2013, U.S. Public Health Service: 4-101.11 "Materials that are used in the construction of UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT may not allow the migration of deleterious substances or impart colors, odors, or tastes to FOOD and under normal use conditions shall be:	F 371	F371-The dry storage shelving and the walk-in-freezer floor has been cleaned. The seven pitchers with fissures and cracks have been removed from the facility, along with the two discolored and scored cutting boards. The non-disposable fingernail brush has been removed. An audit will be conducted by the administrator or designee to ensure that non-food contact surfaces shall be kept free of dust, dirt, food residue, and other debris. An audit will be conducted by the administrator or designee to ensure that fingernail brushes are being used and disposed of properly. Staff was educated on 2/10/15 about sanitation and cleaning of the kitchen. Random audits will be conducted by the administrator or designee 3 times a week times 3 months and weekly thereafter to ensure to ensure proper sanitation is being met. All results will be taken to QA&A for further review and analysis	3/6/15

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F 371	Continued From page 18 (A) Safe; (B) Durable, CORROSION-RESISTANT, and nonabsorbent; (C) Sufficient in weight and thickness to withstand repeated WAREWASHING; (D) Finished to have a SMOOTH, EASILY CLEANABLE surface; and (E) Resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition." 3. Observation of the hand washing sink on 1/22/15 at 11:35 AM showed an unlabeled non-disposable fingernail brush was available for use. According to the 2013 Food Code, U.S. Public Health Service, Hands and Arms, 2-301.11, Clean Condition: "The hands are particularly important in transmitting foodborne pathogens. Food employees with dirty hands and/or fingernails may contaminate the food being prepared..... The greatest concentration of microbes exists around and under the fingernails of the hands. The area under the fingernails, known as the "subungual space," has by far the largest concentration of microbes on the hand and this is also the most difficult area of the hand to decontaminate. Fingernail brushes, if used properly, have been found to be effective tools in decontaminating this area of the hand. Proper use of single-use fingernail brushes, or designated individual fingernail brushes for each employee, during the handwashing procedure can achieve up to a 5-log reduction in microorganisms on the hands." 4. Interview with the Registered Dietitian on 1/22/15 at 2:42 PM revealed she was unaware	F 371		

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F 371	Continued From page 19 the nailbrush was for single use and could not be shared. Further, she verified the floors should be cleaned and equipment that was damaged needed to be replaced.	F 371		
F 441 SS=D	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 professional practice. (c) Linens	F 441	F441-Dining room assistant 1 was given 1 on 1 education specific to opportune times to wash hands, specifically after handling garbage on 2/10/15. All staff will be re-educated on the proper opportunities for hand hygiene during the all staff meeting on February 17, 2015. Random opportunity hand washing will be audited weekly times 3 months and then quarterly thereafter by Infection Control Nurse and/or designee to ensure proper hand washing at appropriate times. All results will be taken to QA&A for further review and analysis.	3/6/15

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F 441	Continued From page 20 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure adequate hand hygiene during one random observation. The findings were: Observation in the main dining room on 1/20/15 at 11:58 AM showed dining room assistant #1 was pouring drinks for residents and delivering them to the tables. During the observation the assistant picked up a discarded paper placemat and napkin from the floor and disposed of the garbage in the waste can. Without any hand hygiene the assistant proceeded to pour drinks for residents. Interview with the infection preventionist on 1/23/15 at 8:45 AM verified the staff member was expected to wash their hands after handling the garbage.	F 441		
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, and resident and family and staff	F 463		

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F 463	Continued From page 21 Interview, the facility failed to provide a functioning call system to receive resident calls on 2 of 2 hallways. The resident census was 39. The findings were: 1. Policy and procedure review titled "Paging system/Call light response" revealed staff was to "answer call lights promptly" and CNAs are paged immediately, nurses are paged 5 minutes after initial call." The following concerns were identified: a. Interview with resident #39 on 1/21/15 at 4:20 PM revealed "at times it takes 20 to 30 minutes" to answer call lights and "it takes longer after dinner." b. Group interview with 10 residents on 1/21/15 at 1:30 PM revealed all attending residents felt staff were slow to respond to call lights. c. Observation on the evening shift on 1/21/15 from 7:35 PM to 9 PM showed the resident call system was not functioning as designed. The call system did not have any sound at the nurses' desk, and the two display boards (one on each hall) displayed the room when the call was initially activated and then would not continue to show the resident rooms until the calls were answered. In addition, interview with CNA #1 at 8:30 PM revealed she was unsure which resident rooms had call lights activated at that time. The CNA revealed she carried a digital pager; however, it was difficult to determine which calls were still active. She stated it was not an effective system and she usually went to the nurses' station to see which rooms were still in need of attention by looking at the computer screen. 2. Review of the 12/22/14 quarterly MDS	F 463	F463- The call light systems was fixed by maintenance on 1/23/15 so that the charge nurses receive a page after 5 minutes. The speakers for the call light system where plugged back in on 1/22/15 so that staff would be notified by an audible voice. On 2/10/15 the speaker cable was moved so that there would less chance of it being unplugged. Maintenance completed an audit of the call system on 2/13/15 to ensure the message boards, audio, and pagers were working correctly. Staff will be educated on 2/17/15 on pager functions, battery replacement, message board display, and audio functions of the call light system. The Director of Nursing or designee will randomly audit employees to ensure they understand how the call system works 5 times a week times 3 months and then weekly thereafter. Maintenance or designee will audit the call light system weekly to ensure that it is functioning properly. All audit results will be taken to QA&A for further review and analysis.	3/6/15

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F 463	Continued From page 22 assessment for resident #29 showed the resident was frequently incontinent. Review of the resident's care plan, updated on 12/26/14, revealed the resident was "able to make it to the bathroom in time if somebody helps me." Further review of the care plan revealed interventions included "I need limited assist with transfers, walking in room and using the toilet" and "answer my call light promptly and help me to the bathroom quickly when I ask." Interview with CNA #3 on 1/21/15 at 7:50 PM revealed the call light for the resident's room had been activated at that time. The following concerns were identified: a. Observation of the resident at 7:58 PM revealed the resident was seated on the side of his/her bed. Interview of the resident at that time revealed the resident needed to use the toilet, but s/he was unable to because the door was locked and s/he couldn't "get in there." b. Observation at 8:08 PM showed the resident got up from the bed, ambulated with a walker to the bathroom door, and attempted to open it. Unable to open the bathroom door, the resident returned to the bed and continued to wait for assistance. c. Observation at 8:12 PM showed LPN #4 walked by the resident's room, and entered another room. At 8:13 PM, the resident again got up from the bed, ambulated to the bathroom door and attempted to open it. Again unsuccessful, the resident returned to the bed. LPN #4 passed by the resident's room again at 8:16 PM. d. At 8:21 PM the resident was observed to ambulate out of his/her room into the hallway. The resident was visibly upset at this time, stating "It's been so long. I changed it and everything is all wet." LPN #3 came from the nurses' station to assist the resident, and interview with the LPN at that time confirmed the resident's bed was wet.	F 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535053	A. BUILDING _____ B. WING _____	C 01/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 463	Continued From page 23 Observation of the computer monitor at the nurses' station, which displayed active call lights, beginning at 7:55 PM revealed the resident's call light remained activated until LPN #3 assisted the resident, a period of 31 minutes. e. Observation on 1/21/15 of the nurses' station call system display at 8:04 PM showed room #120 bed A was activated. Observation showed the call was answered 26 minutes later at 8:30 PM by CNA #1 f. Interview with LPN #1 on 1/22/15 at 9:20 AM revealed the call system initially sent a signal to the CNA pagers and, if the call light was not answered after 5 minutes, sent a second alert to the nurse's pager. g. Observation of a call system test on 1/22/15 beginning at 9:32 AM showed LPN #1 had to replace the batteries in the digital pager on the nurses' medication cart before the test could begin. The call system was then activated, and turned off 8 minutes later. Interview with LPN #1 at 9:40 AM confirmed her digital pager did not receive an alert. Observation with the DON during this same time period showed the main speakers at the nurses' station had been disconnected from the computer, so no audible alerts could be heard. The DON was observed to plug the speakers in to the computer, and the system immediately began to produce an audible alert notifying those in the area that a call light was active. h. A second test was conducted on a call light that was initiated on 1/22/15 at 9:35 AM and staff was asked to leave the light on to check the system function. The test was concluded at 9:57 AM. LPN #1 stated at that time that her digital pager did not sound until just before the system test concluded (over 20 minutes after test began).	F 463		

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F 514 F 514 SS=E	Continued From page 24 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure medical record documentation was complete for 3 of 10 sample residents (#4, #12, #25). The findings were: 1. Review of the November and December 2014, and the January 2015 treatment administration records (TARs) showed resident #4 was to receive calmoseptine ointment to the coccyx two times per day. However, documentation on the TAR was blank 6 times in November 2014, 18 times in December 2014, and 9 times in January 2015. In addition, the resident was to have pressure relief boots applied while in bed. Review of the TARs showed blank documentation 11 times in December 2014 and 15 times in January 2015. The January 2015 TAR also revealed the resident had a skin tear to the left inner wrist that	F 514 F 514	F514- Resident #4 was evaluated by the facility wound care nurse 2-16-15 to ensure skin is not compromised. Resident #12 is care planned for fall risk and staff follows standard of care. Resident #12 fall protocol is inappropriately placed on the TAR and has been removed. Resident #25 will be evaluated by the facility wound care nurse to ensure skin is not compromised. Nursing staff will be re-educated on proper documentation at the 2/17/15 all staff meeting. Nurses will review TARS at change of shift to ensure completion. DON and/or designee will audit TARs 3x weekly x 3 months and then weekly there after using an audit tool to ensure compliance. Facility has purchased eTAR/ eMAR which is scheduled to go live the week of March 9th, 2015. This system requires compliance by end of shift with notifications of incomplete tasks to management. Results will be brought to QA&A for further review and analysis.	3/6/15

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F 514	Continued From page 25 was to be monitored every shift until healed. As of 1/21/15 the TAR showed blank documentation for 13 shifts. 2. Review of the January 2015 TAR showed resident #12 had a fall protocol which was to be checked every shift. As of 1/20/15, there were 9 shifts when the protocol was not documented as having been checked. In addition, the resident had multiple scratches on the upper back and was being monitored for signs and symptoms of infection each shift. As of 1/20/15 there were 9 shifts when the documentation was lacking. 3. Review of the January 2015 TAR showed resident #25 had multiple interventions related to skin care/integrity which were to be documented on each shift. These included application of pressure relief boots, application of calmoseptine ointment with perineal care, and ensuring proper inflation of the wheelchair "ROHO" cushion. As of 1/20/15 there were 10 shifts when the pressure relief boots were not documented; 11 shifts when the ointment was not documented; and 18 shifts when the "ROHO" cushion was not documented as having been checked for proper inflation. In addition, the resident's pain level was to be assessed each shift. As of 1/20/15 there were 11 shifts with no documentation related to the pain assessment. 4. Interview with the DON on 1/23/15 at 1:15 PM verified documentation on the TARs was expected to be completed when the treatment items were done. She further revealed audits of the TARs were not being done to ensure accuracy or completion.	F 514		