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

PRINTED: 04/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536051	A. BUILDING _____ B. WING _____	C 03/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND CARE CENTER	PO BOX 1325 THERMOPOLIS, WY 82443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: On 3/23/15-3/26/15 a recertification and complaint survey was conducted by Healthcare Licensing and Surveys. The complaint was prompted by intake #WY00001884. ADL - Activities of Daily Living CAA - Care Area Assessment CNA - Certified Nurse Aide DON - Director of Nursing MAR - Medication Administration Record MDS - Minimum Data Set PRN - Pro re Nata (as needed) RN - Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in statement of the deficiencies. The plan of correction is prepared and/or solely because it is required by the provisions of federal state and law. Completion dates are provided for procedural processing purposed and correlate with the most recently contemplated or accomplished corrective action and do not necessarily correspond chronologically to date. The facility is of the opinion it was in compliance with requirements of participation or that corrective action was taken.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.	F 164	1. Resident #10 will be provided personal privacy during personal cares. 2. All residents are affected. 3. The facility ensures that personal privacy will be provided to all residents during personal cares. The CNA staff will be in-serviced on providing personal privacy during personal cares.	5/10/15

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

N/A — Administrator — 4/18/15

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.

Change made per Phone call with Brenda Fisher, RN on 5/11/15 @ 1:32 pm. POC accepted. Janice Cole, QMRC

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: DQU011 Facility ID: WY0008 If continuation sheet Page 1 of 19

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F 164	Continued From page 1 The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, the facility failed to ensure privacy was maintained during personal care for 1 of 8 sample residents (#10) observed for personal care. The findings were: Review of the 2/8/15 quarterly MDS assessment showed resident #10 required extensive assistance with toileting and personal hygiene, and had moderate cognitive impairment. The following concerns were identified: 1. Observation on 3/24/15 at 11:22 AM showed CNA #4 entered resident #10's room and assisted with personal cares. The resident was in bed, dressed in only a brief and shirt. The CNA assisted the resident to pull his/her pants on and emptied the resident's Foley catheter collection bag. At no time during this observation did CNA #4 closed the door to the room, or pull the privacy curtain closed, leaving the resident exposed to persons in the hallway.	F 164	4. DNS or designee will conduct three random care observations weekly to ensure that personal privacy is provided during personal cares x 90 days. Audit findings will be reviewed at monthly QA meetings. 5. Compliance date: May 10, 2015	

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F 164	Continued From page 2 2. Interview on 3/25/15 at 5:50 PM with CNA #4 revealed she felt the television on the shelf in the resident's room had provided enough privacy (by blocking the view), however she said she should have closed the door. 3. Interview on 3/26/15 at 6:50 PM with the DON verified the privacy curtain should have been pulled as well as the door closed to provide for resident privacy. 4. Review of the facility policy titled" Quality of Life - Dignity" revised August 2009 showed "... Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures..."	F 164		
F 250 6S=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and medical record review the facility failed to provide social services related to discharge planning for 2 of 2 (#19, #28) sample residents with expressed desire to transfer to another facility, and failed to provide bereavement services for 1 of 1 (#26) sample residents experiencing loss of a roommate. The findings were:	F 250	1. Residents #19 and #28 will received medically related psychosocial services. 2. All residents of the facility are affected. 3. Social Services Manager has been inserviced on the requirements for documenting discharge planning services provided to residents. Social Services Manager has been inserviced on implementation of facility protocol (assessment and care planning) for the provision of bereavement/grief services and the requirement to document those services provided to residents.	5/10/15

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F 250	Continued From page 3 1. Review of the 3/18/15 quarterly MDS assessment showed resident #28 was cognitively intact. Review of a social service note dated 9/25/14 revealed the resident wanted to move to a different facility in a city that was closer to his/her family. The following concerns were identified: a. Review of a 10/15/14 social services note showed the "resident is requesting alternate placement after being denied by the facility and Social Services is to look for alternate placement." No further documentation was noted related to alternate placement. b. Interview on 3/24/15 at 9:09 AM revealed the resident still wanted to transfer to another facility. c. Interview with the Social Services Director on 3/26/15 at 11:40 AM revealed the resident was also denied by another facility, however, the denial was not documented. Further, the Social Services Director stated, "I have it all in my head, but I didn't think to write it down." 2. Review of the 3/1/15 quarterly MDS assessment showed resident #18 was cognitively intact and there was no active discharge planning. The following concerns were identified: a. Review of a social service note dated 9/8/14 revealed the resident wanted to return home independently or move to a group home. Further, the note indicated the resident would need to "get stronger and will have to get back on a waiver" in order to facilitate such a move. b. Review of a physician consult dated 2/16/15 showed the resident wanted to be placed in a more independent living situation. c. Interview with the resident on 3/26/15 at 9:07 PM confirmed the resident would still like to	F 250	4. DNS will review all discharge planning doocumentation for residents requesting discharge for 90 days and report findings to the QA Committee monthly. DNS will review all assessment and care plans for residents with recent loss for 90 days and report findings to QA Committee monthly. 5. Completion by 5/10/2015	

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F 250	Continued From page 4 move to "be closer to family." d. Interview with the Social Services Director on 3/26/15 at 11:40 AM revealed that "paperwork" had been sent to two facilities. Further interview at that time revealed one of the facilities had the resident on a "waiting list"; however, there was no documentation to support this as the Social Services director stated, "I didn't think to write it down." 3. Review of the 1/18/15 quarterly MDS assessment showed resident #26 had diagnoses that included depression. Further review showed the resident received daily medication to manage depression symptoms. The following concerns were identified: a. Interview with the resident on 3/24/15 at 4:45 PM revealed the resident's roommate had recently "passed." b. Review of resident's medical record and care plan failed to show regular monitoring, assessment, or follow up for resident's potential for grief related to loss. c. Interview with the Social Services Director on 3/26/15 at 11:40 AM confirmed the resident had lost a roommate recently and Social Services tried to visit the resident daily to "check on" him/her. Continued interview confirmed there was no documentation or care planning done for resident grief related to the recent loss.	F 250		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253	1. The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and	5/10/15

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F 253	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the facility was clean and well maintained for 7 randomly observed areas. The findings were: 1. Observation of the floor on C-Hall on 3/26/15 at 8:40 AM revealed 2 (12 inch by 12 inch) tiles near the "drain clean out" were chipped or cracked and visibly dirty with an uncleanable surface. 2. Observation of the floor near the secure unit oxygen storage on 3/26/15 at 8:43 AM showed 5 (12 inch by 12 inch) tiles were chipped or cracked and visibly dirty with an uncleanable surface. 3. Observation of hall floor near room 19 on 3/26/15 at 8:47 AM showed 5 (12 inch by 12 inch) tiles that were chipped or cracked and visibly dirty with an uncleanable surface. 4. Observation of the floor outside of the Social Services office on 3/26/15 at 8:48 AM showed 9 (12 inch by 12 inch) tiles that were chipped or cracked and visibly dirty with an uncleanable surface. 5. Observation of the floor in the dish room on 3/26/15 at 8:50 AM showed 10 (4 inch by 4 inch) tiles that were chipped or cracked and visibly dirty with an uncleanable surface. 6. Observation under the nurses' station, near the social services office, on 3/26/15 at 8:53 AM showed 2 (12 inch by 12 inch) tiles that were chipped or cracked and visibly dirty with an uncleanable surface.	F 253	comfortable interior. All residents are affected. 2. All residents are affected. 3. Physical plant manager and administrator developed replacement plan: All chipped and cracked floor tiles cited will be replaced. Kitchen and dry storage area will be completed by 5/10/15. Dish room will be completed the following week and hall areas completed in weekly succession due to logistical issues. All material and supplies will be on site. Housekeeping and Maintenance staff will be in-serviced on how to audit and record tile replacement needs. 4. Monthly audits will be performed x 90 days to ensure that any chipped and cracked floor tile be replaced. Findings to QA monthly. 5. Completed by 5/10/15.	

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F 253	Continued From page 6 7. Observation of the floor in the kitchen on 3/26/15 at 8:58 AM showed 50 (12 inch by 12 inch) tiles that were chipped or cracked and visibly dirty with an uncleanable surface. 8. Observation of the dry storage area of the kitchen on 3/26/15 at 9 AM showed 43 (12 inch by 12 inch) tiles that were chipped or cracked and visibly dirty with an uncleanable surface. 9. Interview with the Maintenance Director on 3/26/15 at 9 AM confirmed the chipped or cracked tiles. He further acknowledged the facility did not have a specific plan with a timeframe to complete those repairs.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual	F 278	1. Resident #46 MDS was corrected and transmitted. 2. All residents identified with MDS for incontinence are affected. 3. The MDS Coordinator will be in serviced on the importance of completing MDS assessments accurately. 4. DNS or designee will audit all MDS completed each week to ensure that the residents bowel and bladder function is accurately completed x 90 days. Audit findings will be reviewed at monthly QA meetings.	5/10/15

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F 278	Continued From page 7 to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $6,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to accurately code continence for 1 of 11 (#46) sample residents. The findings were: Review of the 3/8/15 quarterly MDS assessment showed resident #46 had diagnoses that included Huntington's chorea and other alterations of consciousness. Further review showed the resident was occasionally incontinent of bladder, always continent of bowel, and required the total assistance of one person for toileting. The following concerns were identified: a. Observation on 3/25/14 at 6:35 PM showed the resident was assisted to bed and provided peri-care. Continued observation showed the resident was not offered to use the toilet. b. Interview with CNA #4 on 3/25/15 at 6:47 PM revealed the resident was not incontinent and confirmed the CNA failed to ask if the resident needed or wanted to sit on the toilet. c. Review of the resident's care plan showed the resident was modified to check and change for toileting in January 2015. Interview with the DON on 3/26/15 at 11:09 AM revealed the resident was not able to sit on the toilet and the MDS assessment was in error.	F 278	5. Compliance date: May 10, 2015	

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F 279	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to develop a comprehensive care plan for 1 of 11 sample residents (#21). The findings were: Review of the 3/1/15 annual MDS assessment showed resident #4 triggered for further assessment in the areas of communication and dental care. Review of the communication and dental care CAAs showed the decision was made to care plan both of these areas. However, review of the resident's care plan, last updated September 2014, showed neither of these areas	F 279	1. Resident #4 care plan was corrected to include communication and dental care The facility ensures that comprehensive care plans are developed to describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 2. All residents are affected. 3. Licensed staff will be in serviced on the importance of developing a comprehensive care plan that include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. 4. DNS or designee will audit 3 care plans each week to ensure that the care plans are in accordance with triggered CAAs Audit findings will be reviewed at monthly QA meetings. 5. Compliance date: May 10, 2015	5/10/15

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F 279	Continued From page 9 was care-planned. Interview with the DON on 3/26/14 at 10:45 AM confirmed the facility had not developed a care plan for either of these areas for this resident.	F 279		5/10/15
F 309 88=G	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, and staff interview, the facility failed to adequately treat pain for 1 of 8 sample residents (#21) assessed as having pain. The lack of timely pain intervention resulted in harm for the resident. The findings were: Review of the 1/25/15 admission MDS assessment for resident #21 showed the resident was severely cognitively impaired with a Brief Interview for Mental Status score of zero, and had diagnoses that included Alzheimer's disease, non-Alzheimer's disease, anxiety disorder and depression. The following concerns were identified: 1. Review of nurse charting dated 3/22/15, timed 12 PM, showed resident #21 was complaining of pain with ADLs with "Obvious pain noted	F 309	1. Resident #21 will have pain assessed at least every shift and as needed. Resident #21 will receive adequate and timely administration of prescribed scheduled/PRN pain medications and timely pain management intervention. 2. All residents are affected. 3. The facility ensures that resident's receive timely pain management intervention. Licensed nursing staff will be in serviced on the importance of accurate pain assessment and timely pain management intervention. Licensed nursing staff will be in serviced on the importance of timely reporting of uncontrolled pain to primary care physician and the timely initiation of new pain management interventions. 4. DNS or designee will conduct three random audits each week of resident's receiving pain management intervention. Audit findings will be reviewed at monthly QA meetings. 5. Compliance date: May 10, 2015	

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F 309	Continued From page 10 especially to lower back/hip area." The note further showed the nurse would "request pain intervention from MD [medical doctor]." Review of physician orders showed an order dated 1/16/15 for pain check three times daily. Review of the March 2015 MAR showed the resident was recorded as having pain of "0" on all shifts on 3/22/15. There was no evidence the physician was contacted on 3/22/15 about the resident's pain. Further review of the March 2015 MAR showed the resident had no orders for pain-relieving medication on 3/22/15, other than a regular order for low-dose aspirin 81 mg s/he received every morning. 2. Review of the March 2015 MAR showed the resident experienced a pain level of "10" (on a scale of 1-10 with 10 being the worst pain) on the 3/23/15 AM shift. Review of the medical record showed no evidence the resident's physician was contacted about this high pain level. 3. Review of the 3/25/15 Physician's Record of Visit showed the resident had experienced a decline in condition and a mental status change, was complaining of pain, and had a swollen and painful right ankle. Further review showed new physician orders including the following: Aleve (a non-steroidal anti-inflammatory drug often used to treat pain) 220 mg twice daily as needed for pain, and Tylenol (an analgesic medication) 500 mg every 6 hours as needed for pain. 4. Review of the March 2015 MAR showed the resident experienced a pain level of "6" (on a scale of 1-10 with 10 being the worst pain) on the 3/25/15 AM shift. Further review showed no Aleve or Tylenol was administered to the resident to treat pain during the AM shift.	F 309		

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	535051	A. BUILDING _____ B. WING _____	C 03/26/2015

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THERMOPOLIS REHABILITATION AND CARE CENTER	PO BOX 1325 THERMOPOLIS, WY 82443

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F 309	Continued From page 11 5. Observation of the resident on 3/25/15 beginning at 5:15 PM showed the following: a. At 5:15 PM the resident was seated in a wheelchair in the dining room of the secure unit. The resident said, "Owl" several times and was grimacing and rubbing the area at the top of his/her right thigh. b. At 5:22 PM, RN #1 asked the resident if s/he was okay. The resident did not respond to the question. c. At 5:23 PM, the resident again said, "Owl" and CNA #1 walked over to the resident and checked to ensure the resident's feet were not being bumped. d. At 5:28 PM the resident again said, "Owl" and RN #1 told CNA #2 that she thought someone was going to need to feed the resident. e. At 5:30 PM, CNA #1 and CNA #2 repositioned the resident in her wheelchair. At 5:47 PM the resident stated s/he needed to go to the toilet, and CNA #1 and CNA #2 took the resident from the dining room to his/her room where the aides transferred the resident from the wheelchair to the toilet. During the transfer, the resident repeatedly stated, "Owl" and CNA #2 stated the resident had been "saying that an awful lot lately." f. The resident was returned to the dining room at 6:02 PM, where s/he would not eat dinner. At 6:08 PM, CNA #2 asked the resident "Are you in any kind of pain?" The resident did not respond verbally but continued to fidget, grimace and and periodically say, "Owl" g. Observation at 6:38 PM showed RN #1 was ending her shift, and RN #2 was her replacement. h. Interview with RN #2 at 7:30 PM revealed he had received report from RN #1 the resident	F 309		

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F 309	Continued From page 12 was complaining of pain and had new orders for pain medication. I. Observation at 7:42 PM showed RN #2 administered medications to the resident. Interview with RN #2 at that time revealed the medications administered did not include medication for pain. j. Observation at 7:45 PM showed the resident was taken to his/her room and prepared for bed. The resident moaned, grimaced and said, "Owl" and "Ow-oh-oh-oh!" with transfer from wheelchair to bed, and grimaced and moaned when s/he was rolled from side to side in the bed for incontinence care. CNA #2 stated, "I think [s/he] just hurts all over." k. Further review of the March 2015 MAR showed the resident was not administered any Aleve or Tylenol at any time on 3/25/15. l. Interview with the DON on 3/26/15 at 10:45 AM confirmed the resident should have been treated for pain.	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 function as possible. This REQUIREMENT is not met as evidenced by:	F 315	1. Residents #18 will receive services in accordance with individualized plan of care. 2. All residents at risk for incontinence are affected. 3. The nursing staff will be in serviced on the importance of adhering to individualized care plans and utilizing facility care plan suggestion forms for	5/10/15

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F 315	Continued From page 13 Based on observation, medical record review and staff interview, the facility failed to provide appropriate services to maintain normal bladder function for 1 of 8 residents (#18) assessed as having incontinence. The findings were: Review of the 2/15/15 quarterly MDS assessment showed resident #18 was severely cognitively impaired, and was dependent on staff assistance for toilet use. Further review showed the resident was frequently incontinent, and was on a toileting plan. Review of the pressure ulcer CAA from the 8/19/14 significant change MDS assessment showed the resident was "toileted upon rising, before and after meals at HS [bedtime] and PRN during the day, assisted to toilet on rounds and changed PRN at NOC (night)...[s/he] is mostly aware of [his/her] own toileting needs, however, is generally too late in voicing them, therefore staff must anticipate [his/her] needs." Review of the resident's care plan for urinary incontinence, last updated September 2014, showed the resident had a goal of "...will maintain current level of bladder function through next review." Interventions included "Assist to toilet upon rising, before and/or after meals at HS and PRN during the day/eve." The following concerns were identified: 1. Observation on 3/24/15 beginning at 9:15 AM showed the resident was lying in bed in his/her room and continued to be so until 11:46 AM when CNA#3 entered the room to get the resident up for lunch. Before getting the resident up from the bed, the CNA checked the resident's incontinence brief, and stated it was not wet, because the stripes on the brief were colored yellow, and the stripes turn blue when the brief is wet. The CNA then transferred the resident from bed to	F 315	recommendations regarding anticipated changes to care plan. 4. DNS or designee will conduct three random care observations weekly to ensure that cares are provided according to individualized care plans x 90 days. Audit findings will be reviewed at monthly QA meetings. 5. Compliance date: May 10, 2015	

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F 315	Continued From page 14 wheelchair, and took the resident to the dining room for lunch without offering to take the resident to the toilet, or asking the resident if s/he needed to use the toilet. 2. During interview on 3/24/15 at 11:52 AM, CNA #3 stated the resident did not use the toilet even when s/he was continent, adding "The whole time I've worked here [s/he] hasn't used the toilet. I don't know why." 3. Interview with the DON on 3/26/15 at 10:45 AM revealed the resident was able to use the toilet, and should have been toileted as per the care plan.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure half side rails were assessed for safety for 2 of 3 sample residents (#26, #28) who used side rails. The findings were: 1. Review of the 1/18/15 quarterly MDS assessment showed resident #26 was severely cognitively impaired with a brief interview for	F 323	1. Resident #26 care plan corrected to indicate need for 1/2 bed mobility rails for achieving the highest level of independence. Bed Safety Evaluation completed for Resident #26. Bed Safety Evaluation updated and current for Resident #28. The facility updated the "Bed Safety Evaluation" to include potential for limb entrapment. 2. All residents with mobility devices are affected. 3. The facility will perform a "Bed Safety Evaluation"(to be included in in-service) upon admission. Quarterly safety	5/10/15

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F 323	Continued From page 15 mental status score of 6/15, and diagnoses that included muscle weakness and unspecified fall. Observation on 3/25/15 at 9:55 AM showed a half side rail was attached to the open side of the resident's bed and the other side was against the wall. The device was designed to have gaps between the bars. The gaps were measured, and there was 1 gap between the bars that measured 8 inches by 7 ¼ inches and 2 gaps between the bars that measured 7 ½ inches by 7 ½ inches in size. Review of the resident's medical record revealed that a safety assessment was not completed. The facility failed to address the safety of side rail use or potential for limb entrapment. Additionally, the use of the side rail was not addressed in the resident's care plan. 2. Review of the 3/18/15 quarterly MDS assessment showed resident #28 was cognitively intact, and had diagnoses that included multiple sclerosis. Observation on 3/23/15 at 4:20 PM showed the resident had half side rails attached and in use to both upper sides of the bed. Further observation at that time showed the bed had half side rails to the lower side of the bed that were not in use at that time. The device was designed to have gaps between the bars. The gaps were measured, and there was 1 gap between the bars that measured 8 inches by 7 ½ inches and 2 gaps between the bars that measured 7 ½ inches by 7 ½ inches in size. Interview with the resident on 3/25/15 at 9:50 AM revealed s/he used the side rails to sit up. Observation on 3/25/15 at 11:44 AM showed that during ADL care CNA #6 lowered the side rail and assisted the resident to a sitting position on the side of the bed to prepare for transfer. Review of the "Bed Safety Evaluation" revealed it was completed on 8/9/10. The assessment showed the resident expressed a	F 323	assessments will be completed for re-evaluation of safety and necessity, for those resident's with care planned bed mobility rail interventions. The initiation of 1/2 bed rails for bed mobility and achieving highest level of independence will be care planned accordingly. 4. DNS or designee will conduct audits on all current residents with care planned 1/2 bed mobility rails to ensure Bed Safety Evaluation is complete. DNS or designee will conduct quarterly audit on all current residents with care planned 1/2 bed mobility rails x one quarter. 5. Compliance date: May 10, 2015	

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F 323	Continued From page 16 desire to have side rails raised on bed related to "MS (multiple sclerosis) and difficulty with bed mobility." The assessment failed to address the potential for limb entrapment. Additionally, the use of the side rail was addressed on the care plan to "assist with bed mobility and achieve the highest level of independence with bed mobility." 3. Interview with the DON 3/26/15 at 11:40 AM verified the gaps between the rails posed a safety risk and the facility had not evaluated the side rails related to safety.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure a sanitary environment was maintained in 1 of 2 dining areas (main dining room). The findings were: 1. Observation on 3/25/15 at 11:13 AM showed two (one-time use) Nesquick containers located in the dining room with hand written labels of "regular" and "No-sugar" added on the lids. Further review showed the factory label of one	F 371	1. The facility will ensure a sanitary environment is maintained in 2 of 2 dining areas. 2. All residents are affected. 3. The facility will employ containers that meet the materials, durability, strength and cleanability specifications for multiuse utensils. For the storage of both "sugar" and "non-sugar" instant cocoa, single-use containers were replaced. All defective water carafes were replaced. Dietary staff will be in-serviced on 4-101.11, 4-201.11 and 4-202.11 that the facility must maintain a sanitary environment in all dining areas. 4. Monthly audits will be performed x 90 days to ensure that the facility is	05/10/15

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F 371	Continued From page 17 had "No-sugar" crossed out and "regular" written on the label and the use by date had worn off. Interview with the dietary manager on 3/25/15 at 4:40 PM confirmed the facility refilled the containers with bags of cocoa that the facility received. According to Food Code 2013, U.S. Public Health Service definitions: (2) "Single-use articles" includes items such as wax paper, butcher paper, plastic wrap, formed aluminum FOOD containers, jars, plastic tubs or buckets, bread wrappers, pickle barrels, ketchup bottles, and number 10 cans which do not meet the materials, durability, strength, and cleanability specifications under §§ 4-101.11, 4-201.11, and 4-202.11 for multiuse UTENSILS. 2. Observation on 3/26/15 at 6:36 PM showed 11 water carafes on resident tables that were noted to have fissures and cracks throughout the plastic which would prevent effective cleaning and sanitizing. All 11 of the water carafes were used by the residents during the evening meal. According to Food Code 2013, U.S. Public Health Service 4-101.11 "Materials that are used in construction of UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT may not be allowed the migration of deleterious substances or impart colors, odors, or tastes to FOOD and under normal use conditions shall be: (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."	F 371	employing containers that meet the materials, durability, strength and cleanability specifications for multiuse utensils and replacements will be made as needed. Findings to QA monthly. 5. Completed by 5/10/15.	

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