Hand delivered 7/20/15 cw

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

RECEIVED
WY Dept of Health
JUL 20 2015
Healthcare Licensing and Surveys

PRINTED: 07/02/2015
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
	535025	A. BUILDING _____ B. WING _____	C 06/18/2015

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

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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 6/15/15 through 6/18/15. The survey was prompted by complaint intake WY00002037. The following common abbreviations are used throughout this document: ADLs- Activities of daily living BIMS- Brief interview for mental status CAA- Care area assessment CNA- Certified nurse aide LPN- Licensed practical nurse MDS- Minimum Data Set RN- Registered nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	**Cheyenne Health Care Center- Annual Survey – 6/15-6/18/2015 – Plan of Corrections** Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. This plan of correction serves as the facility's allegation of compliance.	7/23/15 For all Tags
F 164 SS=E	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	F 164 Personal Privacy/Confidentiality Corrective Action The facility NHA has obtained new access to the hospital system for all facility nurses. This will alleviate the need for any manager to pull health information for a resident. The home has removed the Maintenance Directors access to the EPIC system which was given by Cheyenne Regional Hospital. ID of Others	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7/20/15

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 w/ change to pg 7. Changes made per Dawn Stackus, NHA on 7/27/15 @ 11:32 am
DOC: 7/23/15 — 7/27/15

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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 staff interview, and personnel record review, the facility failed to ensure resident clinical record information was kept confidential related to 1 random staff member's (the maintenance director) involvement dealing with private resident health/medical information. The findings were: Interview with the maintenance director on 6/18/15 at 12:05 PM revealed he had access to an electronic medical record system which allowed the facility to share resident specific health information with another provider. During the survey from 6/15/15 through 6/18/15 the maintenance director obtained resident specific lab work and referral documentation for the survey team from this system. The following concerns were identified: a. Review of the personnel record for the maintenance director showed he did not have a background or education related to medical records, healthcare, or resident care. b. The skills shown on the resume/application were facility maintenance skills.	F 164	The NHA/Designee will review the current access for staff members in EPIC to ensure that only direct care staff members have access and that Managers who do have access are on the need to know basis. Systemic Change Education has been provided by the NHA/Designee on/before the date of compliance to the Maintenance Director in regard to pulling of protected Health Information Records. Education has been provided by the DON/Designee on/before the date of compliance in regard to EPIC access for Licensed Nursing staff. Monitoring The NHA/Designee will review all facility EPIC access on a monthly basis to ensure that the appropriate staff members only have access. The audits will extend for 3 months. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then	

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F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for	F 203	reassess the need for continued monitoring based on compliance. Date – 7/23/15 F 203 Corrective Action – No opportunity to correct (the Transfer has already occurred) ID of Others The Social Services Director (SSD)/Designee will review discharges in the past 60 days to review if a formal written notice of discharge was given for each resident that had a facility initiated discharge. Corrective actions will be taken as needed. Systemic Change Education was provided to the NHA and SSD by the District Senior Administrator in regard to the proper requirements of a discharge. The Education will occur on/before the date of compliance. Monitoring The SSD/Designee will track and trend discharges for proper written notices on facility initiated transfers monthly and review the results for trends. The audits will extend for 3 months. Results will be reported to the	

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F 203	Continued From page 3 nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interview, the facility failed to issue a written notice prior to transfer/discharge for 1 of 1 sample residents (#100) who had a facility initiated transfer/discharge. The findings were: 1. Review of the 6/4/15 resident transfer form showed the contact person for resident #100 was not notified of the transfer. The form showed the resident was being transferred due to a need for secured unit placement which the current facility did not provide. Review of the nursing notes from 6/4/15 at 1:30 PM showed the receiving facility called and had a bed available and a driver was sent to transport the resident. The note showed at that time a call was placed to the power of attorney (POA) and a message was left on a machine. Review of a 3 PM note on 6/4/15 showed the POA spoke with the nurse and was upset because they had not been previously notified of the transfer. The note showed the transport was there and the POA declined the transfer. However, the note showed the director of nursing ordered the resident to be transferred and the resident was transferred on 6/4/15. The	F 203	Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date of Compliance – 7/23/15	

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F 203	Continued From page 4 note further showed the administrator would call and speak with the POA. 2. Interview with the administrator on 6/18/15 at 9:20 AM verified the transfer was initiated by the facility due to the need for a secured unit. The transfer was not an emergency and although he remembered talking to the POA, he stated there was nothing in writing. The administrator verified there was no written notice provided and he was unaware of this requirement.	F 203	F 225 – Abuse Reporting Corrective Action The NHA has facilitated completion of investigation for allegations of abuse for resident #41. Upon completion of the investigations the NHA will report the outcomes to the Department of Health by the date of compliance.	
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must	F 225	ID of Others The NHA/Designee will conduct an audit of all incidents and grievances in the past 60 days to ensure that all potential reportable occurrences have been investigated and reported. The audits will occur before the date of compliance. Systemic Change The SSD and NHA will receive education from the Senior NHA/Designee in regard to proper abuse reporting. The education will occur on/before the date of compliance. Corrective actions will be taken as needed. All allegations will be properly reported in accordance with federal law, fully investigated, and the findings of the investigations will be appropriately reported to the state.	

Monitoring

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F 225	Continued From page 5 prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on abuse investigation review, grievance investigation review, staff interview, and policy and procedure review, the facility failed to investigate or report to the state survey agency 1 allegation of abuse involving resident #41. In addition, the facility failed to report 5 of 9 investigated allegations of abuse to the state survey agency. The findings were: 1. Review of the grievance log revealed a 6/8/15 allegation of verbal abuse in which resident #41 accused RN #5 of verbal abuse and stated to the social service director the nurse was very aggressive, rude, verbally abusive, and s/he felt unsafe as a result. The following concerns were identified: a. Review of the grievance log and incident log revealed this allegation was not thoroughly investigated as shown by RN #5 being the only staff member interviewed. Additionally, no residents were interviewed. b. Further review showed the facility failed to report the allegation to the state survey agency. c. Interview with the administrator on 6/18/15	F 225	The NHA/Designee will review all incidents and grievances monthly to ensure all proper investigation and reporting has occurred. The audits will extend for 3 months. Any trends will be reviewed and presented to the QAPI committee by the NHA/Designee. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date of Compliance – 7/23/15	

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F 225	Continued From page 6 at 12:05 PM confirmed the facility failed to interview additional staff or residents, and failed to report the allegation to the state survey agency. 2. Review of 5 incidents of alleged resident to resident physical abuse showed each incident was investigated. The incidents included a 5/15/15 incident between resident #86 and resident #13, a 5/26/15 incident between resident #79 and resident #100, a 6/2/15 incident between resident #83 and resident #64, a 6/10/15 incident between resident #28 and resident #99, and a 6/12/15 incident between resident #93 and resident #57. The following concerns were identified: a. Review of the 5 incidents revealed the facility failed to report any of these allegations to the state survey agency. b. Interview with the administrator on 6/18/15 at 12:05 PM confirmed the facility failed to report the 5 incidents. The administrator stated he understood the requirement was to report allegations of abuse only if substantiated. 3. According to the facility policy titled, "Abuse & Neglect Prohibition" last revised June 2013, under "Investigation" 1. "The facility will conduct an investigation of any alleged abuse/neglect..." 2. "The facility will report such allegations to the state..."	F 225	F 241 Corrective Action Resident Care Related 1. Resident #99 was shaved and the finger nails were cleaned. 2. Resident #72's facial hair was removed. 3. Resident #13's facial hair was removed. 4. Resident #85's long fingernails, dirty were cleaned and trimmed. 5. Resident #38's dirt under fingernails was cleaned. 6. Resident #48's dirty fingernails were cleaned. 7. Resident #63's dirty fingernails were cleaned. 8. Resident #98's facial hair was trimmed and fingernails were cleaned. Dining Related including #2, 3, 7 & 8	
F 241 SS=E	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.	F 241	Residents are currently being served timely; in order to support timely service the home is instituting a host/hostess program that will assist in timely delivery of meals and to serve each table in the correct order is maintained. The order for residents will be taken upon arrival to the dining area as the facility allows for open	

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F 241	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to promote dignity for 5 of 17 sample residents (#2, #3, #48, #87, #98) and 6 non-sample residents (#13, #38, #63, #72, #85, #99) during random observations. The findings were: Related to grooming and personal hygiene: 1. Review of the quarterly MDS assessment dated 5/5/15 showed resident #99 had diagnoses including Alzheimer's disease and depression. Further review showed the resident required extensive assistance for personal hygiene and bathing. Observation on 6/15/15 at 11:56 AM showed the resident had long facial hair on the upper lip and chin. Observation on 6/18/15 at 4:40 PM showed the resident continued to have long facial hair the upper lip and chin. Observation on 6/15/15 at 12:30 PM showed the resident's fingernails on both hands had crusted dark colored matter underneath the nails. Observation on 6/17/15 at 5:40 PM showed the dark colored matter remained. 2. Review of the quarterly MDS assessment dated 4/10/15 showed resident #72 had diagnoses including dementia. Further review showed the resident required extensive assistance for personal hygiene and bathing. Observation on 6/17/15 at 8:44 AM showed the resident had thick white facial hair on the chin. Observation on 6/18/15 at 4:40 PM showed the resident continued to have thick white facial hair.	F 241	dining. Service will be based upon the residents choice of meal as well as arrival in the dining area; some items require more preparation than our daily special to prepare and plate. ID of Others An audit of Residents for nail issues or unwanted facial hair will be completed by the Director of Nursing or designee by the date of compliance. Corrective action will be taken as needed. An audit of meal service timeliness in both dining rooms will be completed by the NHA/Designee and corrective actions will be taken as needed. Systemic Change Education will be provided by the SDC/Designee in regard to proper nail care during showers as well as the need to remove unwanted facial hair for residents. The education will occur on/before the date of compliance and will given to Nursing Staff members. Education will be provided to Nursing & Dining Staff members about the timeliness of meals and how the residents should be served for the meal services. The education will be provided before the date of compliance. Monitoring	

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F 241	Continued From page 8 3. Review of the quarterly MDS assessment dated 1/31/15 showed resident #13 had diagnoses including dementia and had a BIMS score of 3/15 (severe cognitive impairment). Further review showed s/he required encouragement and cueing for personal hygiene. Observation on 6/15/15 at 11 AM revealed the resident had long white facial hair on the chin. Observation on 6/18/15 showed the resident continued to have long white facial hair on the chin. 4. Review of the 6/4/15 quarterly MDS assessment showed resident #85 had diagnoses including depression and required extensive assistance with bathing. Observation on 6/15/15 at 9:40 AM showed the resident had long jagged finger nails with brown grime accumulated underneath the nails. Observation on 6/17/15 at 8:50 AM revealed the resident continued to have long jagged fingernails with brown grime accumulated underneath the nails. 5. Review of the 4/23/15 quarterly MDS assessment showed resident #38 had diagnoses including dementia and hemiplegia, and required extensive assistance with bathing. Observation on 6/15/15 at 11 AM revealed the resident had brown grime accumulated underneath the fingernails. Observation on 6/18/15 at 4:40 PM showed the resident continued to have brown grime accumulated underneath the fingernails. 6. Interview on 6/18/15 at 4:40 PM with CNA #6 confirmed the residents' nails and facial hair were noticeable and should have been addressed. She further revealed nail care and facial hair grooming "should be done in the shower" routinely.	F 241	The NHA/designee will complete random audits 3 times weekly of meal service for timeliness and take corrective action as needed for identified concerns. The DON/Designee will monitor resident grooming to ensure that residents' facial hair is trimmed and that proper nail care occurs; the audit will occur 3x/week. Corrective actions will be taken as needed for identified concerns. Results of the grooming audits and meal service audits will be reported to the Quality Assurance Performance Improvement (QAPI) for 3 months. The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date of Compliance 7/23/15	

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F 241	Continued From page 9 7. Review of the 3/25/15 quarterly MDS assessment showed resident #48 required extensive assistance with dressing and personal hygiene. Observation on 6/15/15 at 11:40 AM revealed the resident's fingernails on both hands had crusted dark colored matter underneath the long nails. Observation on 6/18/15 at 11:04 AM showed the dark colored matter remained, and interview with CNA #1 at that time verified the nails were unclean and should have been cleaned on the resident's shower days. Interview with shower aide #1 on 6/18/15 at 11:05 AM verified the resident's nails were not cleaned on 6/15/15 when last showered. 8. Review of the 6/3/15 quarterly MDS assessment showed resident #63 required extensive assistance with personal hygiene and bathing. Observation on 6/15/15 at 3:25 PM revealed the resident's fingernails were soiled with dark colored matter around the nail beds and several nails were broken and jagged. Observation on 6/18/15 at 5:03 PM showed the resident's nails remained in the same condition. At that time CNA #2 verified the nails needed to be cleaned and trimmed. 9. Medical record review showed resident #98 was admitted to the facility on 2/8/14 with diagnoses which included Parkinson's Disease and Dementia. Review of the 2/25/15 annual MDS showed the resident required extensive assistance of one staff member for personal hygiene. Observation on 6/15/15 at 2:40 PM showed the resident had dirty fingernails in need of a trim. The observation also showed the resident had facial hair in need of a trim. Observation on 6/18/15 at 5:15 PM showed the resident continued to have fingernails that were	F 241		

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F 241	Continued From page 10 dirty underneath and in need of trimming. In addition the resident continued to have facial hair in need of shaving. At that time RN #3 confirmed the resident needed nail care and trimming, and facial hair in need of a shave. Related to dining services: 1. Review of the 4/14/15 quarterly MDS assessment showed resident #87 was independent for eating. Observation on 6/15/15 at 11:52 AM showed the resident ambulated without staff assistance to the dining table and waited for the meal. The resident sat for 25 minutes while other residents at the table who came after him/her ate their meals. The resident was served the meal at 12:17 PM. 2. Observation of dining service on 6/15/15 beginning at 11:20 AM showed resident #2 was seated at a table in the dining room with 2 other residents. One of those other residents already had been served the meal, and was eating. At 11:35 AM, another resident at the table received a meal and began to eat. Resident #2, however, did not receive a meal until 12:05 PM. 3. Observation of dining service on 6/17/15 beginning at 5:15 PM showed resident #3 was seated at a table with other residents, one of whom had already been served a meal, however, resident #3 did not receive a meal until 5:58 PM. 4. Resident group interview on 6/16/15 at 1 PM revealed the 12 residents in attendance had concerns related to timeliness of the dining service. They stated that it was common for them to "wait 30 minutes or more" to be served.	F 241		

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F 241	Continued From page 11 5. Interview with the administrator on 6/18/15 at 5:15 PM revealed timeliness and accuracy of meals was an area that was in the process of being addressed.	F 241	F 244 – Group Grievance Corrective Action A concern form for the laundry issue was completed and the facility is working with HCSG to improve staffing and the overall hiring process. ID of Others Laundry services impact all residents in the home. Interviews will be completed with interviewable residents regarding lost clothing and delay in receiving clean clothing. Corrective actions will be taken as needed. Systemic Change Concerns will be reviewed M-F at Morning meeting with the Customer Service Coordinator as the facility driver. The home will follow the policy and procedure for making corrections or resolutions to the concern. The NHA/Designee will meet with the Outsourced Company Representative weekly for 4 weeks and then monthly in regard to increasing their staffing load for laundry services and resident concerns. Ambassadors will meet with residents or representative two times per month for 30 days and inquire about any laundry issues. Concern forms will be completed as needed.	
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and resident council minutes and memo review, the facility failed to adequately address a grievance from the resident council regarding lost clothing and delay in receiving clean clothing. The resident census was 99. The findings were: Resident group interview on 6/16/15 at 1 PM revealed the 12 residents in attendance had concerns related to the timeliness of receiving their clothing back from laundry, as well as concerns with not receiving all of their items back. They stated this issue had been brought up to the facility before; additionally, they felt the facility did not follow through with the concerns and it was still an issue. The following concerns were identified: a. Review of the 1/28/15 resident council minutes confirmed the group had a concern that clothing was not always returned to residents.	F 244		

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F 244	Continued From page 12 The same concern was brought up at the 2/26/15 meeting. Also, review of a 3/25/15 resident council memo showed, "Residents are concerned that clothes are not being returned even though they are labeled." Review of the facility response showed, "We are finding a lot of clothes with names too faded to read. We are working on ironing on names to clothes we have a hard time reading. As well we are finding a lot of closets with piles of clothes at the bottom." The facility failed to specify a timeframe to resolve this issue. b. Observation of the facility laundry on 6/16/15 at 11:15 AM revealed a backlog of dirty clothing consisting of 2 clothing bins and 2 barrels of clothing with one laundry aide working. Interview at that time with laundry aide #1 confirmed she was the only laundry aide, and there was only one shift in the laundry. She confirmed the laundry was usually backlogged similar to the observation. When asked if the facility had a plan to start a second shift in the laundry she said "no". When asked if the facility planned to hire another laundry aide to assist she stated there was no current plan to increase staff in the laundry. c. Interview with the administrator on 6/18/15 at 2 PM revealed the laundry staff are part of an outsourced company, and the facility control is limited. He stated the facility sometimes sends a staff member to assist.	F 244	Monitoring The Customer Service Coordinator will review concerns monthly, specifically any laundry based concerns, to ensure the concerns are addressed timely and followed through upon. Resident council minutes will be reviewed monthly for any laundry concerns. This will occur for 3 months. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date of Compliance 7/23/15	
F 250 SS=E	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.	F 250	F 250 – Social Services Corrective Action The facility made a change within the Social Services department to employ a Social Worker with experience in the role. The home is presently working with the Wyoming Guardian Group and local courts to petition the courts for a Guardian to be appointed for Resident #87.	

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F 250	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on interview with staff and medical record review, the facility failed to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being for 3 of 3 sample residents (#2, #87, #94) identified with social service needs. The findings were: 1. Review of the medical record face sheet showed resident #87 was admitted to the facility on 10/21/14 with diagnoses of hypothyroidism, glaucoma, hearing loss, history of fall, anxiety disorder, blindness/low vision, and arthropathy. The following concerns were identified: a. Review of a consultant physician's initial evaluation dated 2/3/15 showed "Upon interview, the patient is not able to coherently say the circumstances and the reasons for [him/her] being at the SNF [skilled nursing facility], and unable to coherently explain the circumstances surrounding [his/her] arrival to the SNF and what is currently occurring in terms of [his/her] medical care. At this time, the patient does not have the capacity to leave the SNF AMA [against medical advice]; nor does [he/she] have the capacity to refuse essential, potentially-life-saving procedures and treatments that are the standard of care for his/her medical condition(s). At this time, I would concur with pursuit of surrogate decision making/guardianship as appropriate." b. Review of a social service note dated 4/10/15, a letter written by the physician dated 4/7/15, and a letter written by the social service director dated 4/9/15 showed the facility and the physician initiated a process to obtain a guardian	F 250	Resident #2 is scheduled to have cataract surgery. Resident #94 is set to see an urologist for kidney stones. ID of Others Ambassadors will meet with residents or their representative to identify any unmet social service needs. Corrective actions will be taken as needed. The past 60 days of medical records will be reviewed by the DON/Designee to determine any unmet medically related social service needs. Corrective action will be taken as needed. Systemic Change Education will be provided by the NHA/Designee to the Social Service Director on assisting with resident medically related social service needs. Residents will be evaluated upon admission and quarterly for social service needs. A tracking log will be utilized to track identified social service needs and follow up. Monitoring The SSD/designee will track and trend the resident medically related social service needs monthly and follow up.	

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F 250	Continued From page 14 for a resident. Review of these letters showed they were addressed to: "To Whom It May Concern" with no clear indication of who the letters were sent to and no confirmation that these letters were received. c. Interview with the administrator on 6/18/15 at 1:30 PM confirmed the resident still did not have a guardian at that time and he was unaware if additional attempts had been made to follow up on the status of guardianship for the resident since the letters were sent in April 2015. d. Interview with the social services director on 6/18/15 at 1:30 PM revealed she had recently taken over the position and was unaware the resident was in need of a legal guardian and had not been involved in the process thus far. 2. Review of the 11/12/14 annual MDS assessment showed resident #2 had limited vision. Review of a social progress note dated 1/29/15 showed a care conference had been held, and the resident's son stated the doctor wanted the resident to have a cataract removed. The son further stated the cataract removal had not been scheduled, and he did want the resident to have the procedure. Further review of the medical record showed no evidence this request was addressed. 3. Review of the medical record showed resident #94 had a telephone order dated 4/7/15 for the resident to see a urologist for renal (kidney) stones. Further review of the medical record showed no evidence this order was addressed. 4. Interview with the administrator on 6/18/15 at 1:32 PM revealed that referrals to specialists were typically handled by social services, and confirmed the referrals for residents #2 and #94	F 250	Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date of Compliance 7/23/15	

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F 250	Continued From page 15 had not been addressed. He stated there had been turnover in the social service position, and the previous holder of the position had not made the new position holder aware of resident needs that were pending.	F 250	F-253 Corrective Action: #1. Room #133: The divider between the bathroom and resident room will be cleaned and /or replaced. Room #134: The divider between the bathroom and resident room will be replaced. Room #134: The divider between the floor and the hallway will be replaced. Room #132: The divider between the resident room and the hallway will be cleaned and/or replaced. Room #132: The divider between the resident room and the bathroom will be cleaned and/or replaced. Room #135: The divider between the resident room and the hallway will be replaced. Room #135: The divider between the resident room and the bathroom will be replaced. Room #130: The cracked floor tile by the right wall of the room will be replaced. Room #137: The damaged floor tile by the bathroom door will be replaced. Room #139: The right side bathroom floor will have the crack cleaned and repaired.	
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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 5 of 5 resident hallways (North Hallway, South Hallway, Short Hallways 1, 2, 3) were clean and in good repair. The findings were: 1. Tour of the facility on 6/18/15 from 8 AM through 9:30 AM identified the following concerns with floors: a. The divider between the bathroom and resident room floor in room #133 had a 0.5 inch gap that was darkened with dirt and debris. b. The divider area between the bathroom and resident room floor in room #134 had the divider missing 35 inches long and 0.25 inches wide that was darkened with collected dirt and debris. c. The divider area in room #134 between the floor and the hallway had the divider missing 42 inches across and 1.5 inches wide that was darkened with collected dirt and debris. d. The divider between resident room #132 and the hallway had a 2 inch by 18 inch area that	F 253		

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F 253	Continued From page 16 was darkened and collecting debris. e. The divider between the resident room and bathroom in room #132 had the divider separated 35 inches by 0.5 inches that was darkened with dirt and debris. f. The divider between resident room #135 and the hallway had an 8 inch by 1 inch damaged area that was darkened and collecting dirt and debris. g. The divider between resident room #135 and the bathroom was missing 35 inches across and 1 inch wide and was darkened and collected dirt and debris. h. The floor by the right wall in room #130 had an 11 inch crack across the tile which was darkened with dirt and debris. i. The floor by the bathroom door in room #137 had a damaged and missing area 36 inches across that was darkened and collected dirt and debris. j. The floor to the right in the bathroom of room #139 had a 15 inch crack that was darkened with dirt and debris. k. The floor in room #140 had 1 cracked tile by the bathroom entrance that was 6 inches long and darkened with dirt and debris. l. The bathroom floor in room #141 had a 35 inch crack across the entrance that was darkened with dirt and debris. m. The bathroom floor of room #142 had a chipped out area 13 inches long that was darkened with dirt and debris. n. The divider between the bathroom and resident room floors in room #153 was separated 36 inches across and was darkened with dirt and debris. o. The floor in room #152 had 15 cracked tiles (each tile was 12 inches by 12 inches) that were darkened in the cracks with dirt and debris.	F 253	Room #140: The cracked bathroom entrance floor tile will be replaced. Room #141: The cracked bathroom entrance floor tile will be replaced. Room #142: The chipped area in the bathroom floor will be replaced. Room #153: The divider between the bathroom and resident room will be replaced. Room #152: The cracked floor tiles will be replaced or repaired. Room #152: The cracked bathroom floor will be replaced or repaired. Room #145: The bathroom and resident room divider will be replaced. Room #148: The cracked tiles across from the room in the hallway will be repaired or replaced. Room #148: The cracked tile in from of the resident room will be replaced. Room #142: The cracked tiles in the hallway near the fire doors will be repaired or replaced. Room #128: The cracked floor tiles in front of the door will be replaced or repaired. Room #127: The tile(s) near the first bed will be repaired or replaced. Room #126: The divider in the bathroom and the room will be repaired or replaced. Room #125: The non-skid strips in the bathroom will be replaced and/or removed.	

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F 253	Continued From page 17 p. The bathroom floor in room #152 had a crack 30 inches across and a second crack at the back 24 inches across that were darkened with dirt and debris. q. The bathroom and resident room divider in room #145 was separated and the separation was darkened with dirt and debris. r. The hallway across from room #148 had a 94 inch crack across that was darkened with dirt and debris. s. One tile by the entrance to room #148 was cracked 6 inches across that was darkened with dirt and debris. t. The hallway floor by the fire doors near room #142 was cracked 62 inches across and darkened in the crack with dirt and debris. u. In room #128 by the front door there were 5 floor tiles with multiple cracks that were darkened with dirt and debris. v. The floor in room #127 by the first bed had an area of tile missing 4 inches by 3 inches that created an uncleanable surface. w. The bathroom and room divider in room #126 was separated and the separation was darkened with dirt and debris. x. The bathroom floor of resident room #125 had three non-skid strips measuring 18 inches long which were peeling up at the edges. y. The bathroom floor of resident room #125 had a crack measuring 16 inches that was darkened with dirt and debris. z. The bathroom floor in resident room #155 was cracked 18 inches and was darkened with dirt and debris. aa. The bathroom floor in resident room #105 was cracked and chipped 40 inches across. bb. The floor by the entrance to room #103 had multiple cracks 18 inches across that were darkened with dirt and debris.	F 253	Room #125: The cracks in the bathroom floor will be repaired and/or the floor replaced. Room #155: The cracks in the bathroom floor will be repaired or the floor replaced. Room #105: The cracks in the bathroom floor will be repaired or the floor replaced. Room #103: The cracks in the floor by the entrance to the room will be repaired or the floor replaced. Room #102: The cracked tiles in the resident room floor will be repaired or replaced. #2. Room #133: The right inner doorframe will be repaired and cleaned. Room #130: The right bottom side of the doorframe will be repaired. Room #138: The right front doorframe inside the room and the baseboards will be repaired. Room #138: The right front door kick-plate will be repaired or replaced. Room #139: The front door gauged areas will be repaired. Room #126: The front door kick-plate will be repaired or replaced. Room #105: The metal outer doorframe will be repaired.	

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F 253	Continued From page 18 cc. The floor in resident room #102 had multiple cracks, the longest of which measured 13 inches across, which were darkened with dirt and debris. 2. Tour of the facility on 6/18/15 from 8 AM through 9:30 AM identified the following concerns with doors and doorframes: a. The right inner doorframe to room #133 was separated from the wall at the bottom 8 inches across and 2 inches wide that was darkened with dirt and debris. b. The right bottom side of the doorframe in room #130 was chipped 5 inches by 2 inches. c. The right front doorframe inside of room #138 had a chipped area and a loosened baseboard 4 inches from the floor. d. The right front door kickplate of room #138 had a 35 inch area that was torn loose. e. The front door to room #139 on the inside had a gauged area 8 inches across at 36 inches in height from the floor. f. The front door kickplate for resident room #126 was cracked at 11 inches from the bottom, with a jagged piece sticking out. g. The metal outer doorframe to resident room #105 was bent at 7 inches from bottom, sticking out from the framing. 3. Tour on 6/18/15 from 8 AM through 9:30 AM identified the following concerns with walls and baseboards: a. The bathroom wall by the sink in room #131 had a 3 inch crack that was dirty. b. The back wall above the heat vent in room #131 had peeling wallpaper 36 inches across. c. The baseboard near the front door to the right in room #130 was pulled loose 3 inches by 3 inches.	F 253	#3. Room #131: The crack in the bathroom wall will be repaired. Room #131: The back wall wallpaper above the heat vent will be repaired or replaced. Room #130: The baseboard near the front of the door will be repaired or replaced. Room #139: The wall by the toilet with paint peeling will be repaired. Room #141: The baseboard by the right entrance bathroom door will be repaired or replaced. Room #128: The baseboard in the bathroom will be repaired or replaced. Room #127: The baseboard in the bathroom entrance will be repaired or replaced. Room #127: The bathroom inner wall will be repaired. Room #125: The baseboard to the right of the bathroom door will be repaired or replaced. Room #155: The bathroom wall paint behind the toilet and the wall paint next to the sink will be painted. Room #154: The bathroom wall crack by the toilet will be repaired. Room #120: The corner of the wall by the closet will be repaired.	

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F 253	Continued From page 19 d. The wall by the toilet in the bathroom of room #139 had paint peeling across 36 inches and varying in height starting at 4 inches from the floor. e. The baseboard by the right entrance bathroom door to room #141 was pulled away from the wall 9 inches on the left and 10 inches on the right. f. The baseboard in the bathroom of room #128 by the sink was pulled loose from the wall 5 inches by 4 inches. g. In room #127 the baseboard between the closet and bathroom entrance was loose 8 inches across. h. The bathroom inner wall of room #127 had a 3 inch by 2 inch chipped out area by the door. i. In resident room #125, the baseboard to the right of the bathroom door was pulled loose from the wall 10 inches by 4 inches. j. The bathroom wall of resident room #155 had paint missing behind the toilet, measuring 6 inches by 4 inches. The wall next to the sink had an area of paint missing measuring 10 inches by 3.5 inches. k. The bathroom wall of resident room #154 had a crack by the toilet measuring 21 inches. l. The corner of the wall by the closet in resident room #120 had a piece missing with the metal underneath showing measuring 4 inches by 1 inch. 4. Tour on 6/18/15 from 8 AM through 9:30 AM identified the following concerns with shower rooms: The north shower room had clutter consisting of 4 bedside commodes in storage, 3 shower chairs, 1 coke bottle on the floor, a tub out of operation stored with various items, and rust along the floor on each side of the weight scales	F 253	North Shower Room: The north shower room will be de-cluttered, the rust repaired on each side of the weight scales, the shower head repaired or replaced, and the floor tiles in the front of the door repaired or replaced. #5. The bathroom floors in rooms #134, 137, 130, 138, 139, 144, 146, 128, 127, 155, 154, 148, 149, 117, 118, 119, 120, 114, 121, 111, 110, 102, 103, and 106 will be cleaned. The handrails throughout the facility will be cleaned. The hallways and resident areas will be cleaned with the urine odor addressed. Identification of Others: The Maintenance Director and/or Designee will conduct a facility audit to address any additional items addressed in the "Corrective Action" area of this Plan of Correction. Systemic Changes:	

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F 253	Continued From page 20 used to weigh residents in wheelchairs. In addition, the shower head was loosely dangling with no area to hang it up, and there were 2 chipped tiles on the floor in front of the front door that measured 4 inches by 4 inches. 5. Tour on 6/16/15 at 11:10 AM, 6/17/15 at 9 AM, and 6/18/15 from 8 AM through 9:30 AM identified the following concerns with dirty floors and handrails: a. The bathroom floors in room #'s 134, 137, 130, 138, 139, 144, 146, 128, 127, 155, 154, 148, 149, 117, 118, 119, 120, 114, 121, 111, 110, 102, 103, and 106 were dirty and sticky to the touch during each observation. b. The initial tour of the facility on 6/15/15 at 9 AM and the environmental tour on 6/18/15 from 8 AM through 9:30 AM showed the handrails throughout the facility were sticky to the touch. c. Periodic observations during the survey from 6/15/15 to 6/18/15 revealed the facility hallways and resident areas had a noticeable urine odor. Interview with the maintenance director on 6/18/15 at 10:25 AM revealed he was aware of the issues identified during the survey. However, he confirmed there was no plan with a specific timeframe to address those issues. Interview with the housekeeping supervisor on 6/18/15 at 11:05 AM revealed she was aware of the cleanliness issues identified during the survey. She stated housekeeping hours and staff were limited and there was no plan with a timeframe to increase hours or staff in housekeeping.	F 253	The Maintenance Director and/or Designee will conduct routine audits to confirm the areas identified in the "Plan of Correction" are part of the Preventative and/or Maintenance Schedule. Monitoring: The Maintenance Director and/or Designee will report the results of the audits and the work accomplished to the monthly QAPI for review and recommendations. Date of Compliance 7/23/15	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279	F 279 Corrective Action The care plan for resident #11 has been updated to reflect mechanical soft diets and thickened liquids. The care plan for resident #69 has been updated to reflect left upper arm fistula and to not take blood pressure in the affected arm. ID of Others Care plans of residents with mechanically altered diets and / or thickened liquids will be reviewed and updated as needed to reflect diet and thickened liquid orders by the director of Nursing or designee	

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F 279	Continued From page 21 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 staff interview and medical record review, the facility failed to ensure the care plan was updated to include current interventions for 2 of 17 sample residents (#11, #69). The findings were: 1. Review of the 3/24/15 annual MDS assessment showed resident #69 required supervision and one person assist related to eating. Review of the 3/17/15 physician diet order showed the resident was on a mechanically altered diet and nectar thickened liquids. The following concerns were identified: a. Review of the resident's 3/26/15 care plan for fluid deficit failed to be updated to reflect the	F 279	Care plans of residents on dialysis will be reviewed for any precautions and updated as needed by the Director of Nursing or designee. Systemic Change Licensed nurses and the interdisciplinary team will be educated by the Staff Development Coordinator or designee on updating care plans as needed and including mechanically altered diets, thickened liquids and dialysis precautions. Care plans will be reviewed upon admit, significant changes of condition and quarterly per MDS schedule and updated as needed for mechanically altered diet, thickened liquids and dialysis precautions. Telephone orders and new orders will be reviewed in clinical meeting and care plans updated as needed by director of Nursing or designee. Monitoring Random audits of care plans for mechanically altered diets, thickened liquids and dialysis precautions will completed by the director of Nursing or designee weekly for 3 months with corrective actions as needed. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will	

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F 279	Continued From page 22 approach of providing liquids at the nectar thick consistency ordered by the physician. b. Review of the 3/13/15 care plan for weight loss/nutrition showed an approach to provide the diet as ordered; however, it failed to show what the diet order was (mechanical soft). c. Interview with corporate RN #1 and the administrator on 6/18/15 at 6:45 PM verified the diet order and thickened liquids should be specified on the care plan. 2. Medical record review showed resident #11 was admitted to the facility on 10/31/11 with diagnoses which included end stage renal disease. Observation of the resident on 6/17/15 at 1:10 PM showed the resident had a left upper arm fistula for dialysis. The resident stated s/he had been receiving dialysis for 14 years. The following concerns were identified: a. Review of the care plan showed the resident had a care plan for dialysis. Review of the entire care plan revealed failure to include the resident's left upper arm fistula, and the requirement of staff to avoid taking blood pressures in that arm. b. Interview with the MDS coordinator on 6/18/15 at 11:45 AM confirmed the care plan should include the left upper arm fistula and for direct staff not to take blood pressures in that arm.	F 279	evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date of Compliance 7/23/15	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280	F 280 Corrective Action Resident #70 is bilingual. The care plan will be updated to reflect this and other interventions for effective communication. Routine caregivers for resident #70 will be educated on communication care plan by Staff Development Coordinator or designee. ID of Others Residents with communication barriers will be identified and care plan updated to reflect interventions for effective communication by the Social Service Director or designee by the date of compliance. Systemic Change Staff will be educated by the Staff Development Coordinator or designee on development and following care plans for residents with communication barriers. Care plans for residents with communication barriers will be	

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F 280	Continued From page 23 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to develop a care plan related to communication for 1 of 1 sample residents (#70) identified with communication needs. The findings were: Review of the 11/25/14 annual MDS assessment showed resident #70 had diagnoses including Alzheimer's disease and symbolic dysfunction. The area for communication required additional evaluation, and the CAA was completed. Review of the CAA showed the resident had a cognitive impairment and "can both speak and understand English but prefers to speak in Spanish. Translator used for Communication." A decision was made to proceed and develop a care plan for the area of communication. The following concerns were noted: 1. Observation on 6/17/15 at 12:35 PM showed	F 280	developed upon admission, and reviewed and updated quarterly or with significant change of condition by MDs Coordinator or designee. Monitoring Random audits of care plans for residents with communication barriers will be completed weekly for 4 weeks and then monthly for 2 months by the Social Service Director. Corrective actions will be taken as needed. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date of Compliance 7/23/15	

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F 280	Continued From page 24 CNA #9 provided toileting assistance to the resident. The CNA provided verbal instructions to the resident in English and the resident replied in Spanish. Interview with the CNA at that time revealed she was unsure of the resident's communication abilities and stated the resident gets frustrated when she and other aides do not understand. The CNA further stated she thought the resident had a communication board, but was unsure where it was located. She stated she was told to speak very loudly in one ear as the resident had difficulty hearing. 2. Observation on 6/17/15 at 1:35 PM showed CNA #5 provided toileting assistance to the resident. The CNA cued the resident in English and the resident responded in Spanish. Interview at that time revealed the CNA believed the resident was "100% with English," and could speak three different languages. 3. Review of the care plan revealed nothing related to the resident's communication needs and preferences. 4. Interview on 6/18/15 at 1:30 PM with the social services director, the administrator, corporate RN #1, MDS coordinator, and RN #4 confirmed there was no communication care plan for the resident. They further revealed they are unsure of the resident's true abilities in English, and confirmed the resident would appear frustrated at times with not being understood. The MDS coordinator stated she provided the resident with a translator when conducting MDS assessments. She further confirmed the resident did have a hearing loss and stated that it was a "mild" loss.	F 280	F 282 Corrective Action By Date of compliance the dietician will review fluid needs for resident #69 and update care plan and diet tray card as needed. After dietician review, staff who routinely care for resident # 69 will be educated on plan of care, including hydration. By date of compliance the Director of Nursing or designee will evaluate care needs for resident #12 and update care plans as needed. After review, staff who routinely care for resident #12 will be educated on plan of care, including incontinence management and positioning. By date of the compliance the Director of Nursing or designee will evaluate assistance needed at meal time for resident #24 and update care plan as needed. After evaluation the Director of Nursing or designee will educate staff who routinely care for resident #24 on plan of care, including assistance with meals. By date of compliance the Director of Nursing or designee will evaluate assistance needed at meal time for resident #99 and update care plan as needed. After evaluation the Director of Nursing or designee will educate staff who routinely care for resident	
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		

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F 282 SS=E	Continued From page 25 PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure the care plan was implemented for 3 of 17 sample residents (#12, #69, #83) and 2 non-sample residents (#24, #99). The findings were: 1. Review of the 3/26/15 fluid deficit care plan showed resident #69 was at a risk of fluid deficit related to dementia and use of a diuretic medication. Review of the care plan approaches showed "place fluids at bedside...provide 6-8 ounces of extra fluids at each meal time as tolerated." The following concerns were identified: a. Observation on 6/15/15 at 5:35 PM and on 6/16/15 at 5:11 PM showed the resident was able to handle the drinking glass without staff assistance; however, was not provided the extra 6-8 ounces of fluids with these meals. Each of these evening meals were served with approximately 8 ounces total of thickened water. b. Observation on 6/15/15 at 3:27 PM and 6/17/15 at 9:40 AM revealed fluids were not available for the resident at the bedside. c. Interview with the administrator and the registered dietitian on 6/17/15 at 3:30 PM verified the care plan was expected to be followed. 2. Review of the 4/13/15 significant change MDS	F 282	#99 on plan of care, including assistance with meals. By date of compliance the Director of Nursing or designee will update resident #83's care plan to reflect refusal to wear colored arm band and will be updated to include "no B/P in left arm r/t fistula". After care plan updat the Director of Nursing or designee will educate staff who routinely care for resident #83 on plan of care, including dialysis precautions. ID of Others Care plans of residents with thickened liquids, wounds, incontinence, requiring assistance with meals and dialysis resident will be reviewed and updated as needed to reflect current interventions by the Director of Nursing or designee. Staff assignments sheets will be updated to reflect needs in areas of thickened liquids, wounds, incontinence, assistance with meals and dialysis precautions. Systemic Change Licensed nurses and interdisciplinary team will be educated on by Staff Development Coordinator or designee on updating and following the care plan including thickened liquids, mechanically altered diets, wounds,	

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F 282	Continued From page 26 assessment showed resident #12 required the extensive assistance of two persons for ADLs including bed mobility, dressing, and toilet use, and was totally dependent on the assistance of two persons for transfers. Further, the assessment showed the resident had an unstageable pressure ulcer that measured 4 cm by 4 cm. Review of resident's care plan for incontinence, updated 6/17/15, showed the resident was to be checked and changed every 2 hours. Review of the resident's care plan for pressure ulcers, last reviewed on 6/17/15, showed the resident was to have "rest periods in bed between meals". The following concerns were identified: a. Continuous observation on 6/18/15 beginning at 9:47 AM showed the resident was up in his/her wheelchair, sitting in the front area near the facility entrance. At 10 AM, the resident was taken back to the activity room. The resident was not checked for incontinence, or repositioned. The resident's participation in the activity was minimal. At 10:43 AM, the resident was wheeled back to the front area near the facility entrance and left there. The resident was not checked for incontinence or repositioned. At 11:15 AM, the resident was again taken to the activity room, which also functioned as a dining room for meals, and was not checked for incontinence or repositioned. At 1:08 PM, (3 hours and 21 minutes after observation began) the resident was taken to his/her room and laid down in bed. The resident's incontinence brief was changed at that time, and CNA #3 revealed the brief was wet. b. Interview with CNA #3 on 6/18/15 at 1:13 PM confirmed that was the first time the resident had been laid down or checked for incontinence since "we got [him/her] up for breakfast." Review of posted facility dining times revealed breakfast	F 282	incontinence, assistance with meals and dialysis precautions. Assignment sheets will be updated by director of Nursing or designee to include thickened liquids, skin management, incontinence, assistance with meals and dialysis precautions. Monitoring Random observation audits will be completed by Director of Nursing or designee weekly for 3 months to determine if care provided matches plan of care, including thickened liquids, wounds, incontinence, assistance with meals and dialysis precautions. Corrective action will be taken as needed. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date of Compliance 7/23/15	

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F 282	Continued From page 27 was served at 7:30 AM. c. Interview with the facility administrator and corporate RN #1 on 6/18/15 at 6:45 PM confirmed the care plan for the resident should have been followed. 3. Review of the nutrition care plan last dated 6/11/5 showed resident #24 was to be provided meal assistance as needed, and staff were to encourage fluids. Observation on 6/16/15 at 5:11 PM showed the resident was served a meal. The resident began eating slowly and then started to dose on and off until the end of the observation at 6 PM. During this 49 minutes the resident was not offered any encouragement or assistance by the staff. 4. Review of the 5/5/15 quarterly MDS assessment showed resident #99 required extensive assistance with one person physical assist for eating. Review of the nutrition care plan last dated on 4/5/15 revealed the resident was to be provided meal assistance as needed and staff were to encourage fluids. Observation on 6/16/15 at 5:38 PM showed the resident was seated at the table with a meal. The resident made no self attempt to eat or drink. At 6 PM (22 minutes later) CNA #1 encouraged the resident to eat something, and the resident declined. The CNA then moved onto another resident at the table. 5. Review of the admission MDS dated 1/29/15 showed resident #83 had diagnoses including end-stage renal disease. Review of the hemodialysis care plan, reviewed 3/27/15, showed an approach of a "colored arm band on the arm that has the shunt indicating 'No B/P [blood pressure] this arm.'" Observation on 6/17/15 at 1:08 PM showed the resident had a	F 282		

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F 282	Continued From page 28 fistula on the left forearm, but no arm band. Interview at that time with the resident confirmed s/he did not have an arm band to indicate to staff not to take blood pressure readings on that arm and that it was "just natural knowledge." Interview with the MDS coordinator on 6/18/15 at 11:45 AM confirmed the care plan should include the left forearm fistula and direct staff not to take blood pressures in that arm.	F 282	F 312 – Dependent ADL cares Corrective Action The Director of Nursing or designee will evaluate resident #98's toileting and personal hygiene needs, update care plan and assignment sheet. Staff has provided bathing, nail care and removal of facial hair and nail care for resident # 98.	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure required assistance was provided for 2 of 17 sample residents (#48, #98) and 7 non-sample residents (#13, #24, #38, #63, #72, #85, #99) who required assistance with various ADLs. The findings were: 1. Review of the 2/25/15 annual MDS assessment showed resident #98 had diagnoses which included Parkinson's Disease and Dementia, required extensive assistance of 2 staff members for toileting and personal hygiene. The following concerns were identified: a. Observation on 6/15/15 at 3:20 PM showed CNA #10 and RN #3 used a sit to stand lift to transfer the resident to the toilet. The	F 312	The Director of Nursing or designee will evaluate resident #24's level of assistance needed with meals, update care plan and assignment sheet. Staff has provided removal of facial hair and nail care for resident # 24. The Director of Nursing or designee will evaluate resident #99's level of assistance needed with meals, update care plan and assignment sheet. Staff has provided removal of facial hair for resident # 99. Staff has provided nail care to resident #48. Staff has provided nail care to resident #63. Staff has provided facial hair to resident #72. Staff has provided facial hair to resident #13. Staff has provided nail care to resident #85. Staff has provided nail care to resident #38.	

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F 312	Continued From page 29 resident was incontinent of urine and the urine had soaked through the resident's pants to halfway down his/her legs in the back. The CNA had to leave the room to find pants, and the residents pants were partially down which exposed the urine soaked areas to the residents inner knees and back of his/her calves. When the aide returned, personal care was provided. However, she failed to wipe the areas of the back of the upper legs, inner knees, and back of the calves which had been exposed to the urine. Interview with the CNA and RN after the observation confirmed the requirement was to clean all areas of a resident that had exposure to urine. b. Observation on 6/15/15 at 2:40 PM showed the resident had dirty fingernails in need of a trim. The observation also showed the resident had facial hair in need of a trim. Observation on 6/18/15 at 5:15 PM showed resident #98 continued to have fingernails that were dirty underneath and in need of trimming. In addition, the resident continued to have facial hair in need of shaving. At that time RN #3 confirmed resident #98 needed nail care and trimming, and facial hair in need of a shave. 2. Review of the 4/22/15 admission MDS assessment showed resident #24 required limited assistance for eating. Review of the nutrition care plan last dated 6/11/15 revealed the resident was to be provided meal assistance as needed, and staff were to encourage fluids. Observation on 6/16/15 at 5:11 PM showed the resident was served a meal. The resident began eating slowly and then started to dose on and off until the end of the observation at 6 PM. During this 49 minutes the resident was not offered any encouragement or assistance by the staff.	F 312	ID of Others The Director of Nursing or designee will complete observation audits by the date of compliance for nail care, facial hair, toileting, and timely meal assistance. Corrective actions will be taken as needed. Systemic Change: The Staff Development Coordinator or designee will educate nursing staff by the date of compliance on providing assistance with ADL's including timely assistance with meals, nail care, facial hair and toileting and incontinence care. Ambassadors will complete routine rounds to check nail care, facial hair, timely assistance with meals and toileting concerns. Any findings will be reported to nursing management for follow up. Monitoring The Director of Nursing or designee will conduct observation audits of ADL's three times weekly for three months which will include nail care, facial care, timely assistance with meals and toileting and incontinence care. Corrective actions will be taken as needed. Results will be reported to the Quality Assurance Performance Improvement	

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F 312	Continued From page 30 3. Review of the 6/5/15 quarterly MDS assessment showed resident #99 required extensive assistance with one person physical assist for eating, personal hygiene, and for bathing. Review of the nutrition care plan last dated on 4/5/15 revealed the resident was to be provided meal assistance as needed and staff were to encourage fluids. Observation on 6/16/15 at 5:38 PM showed the resident was seated at the table with a meal. The resident made no self attempt to eat or drink. At 6 PM (22 minutes later) CNA #1 encouraged the resident to eat something, and the resident declined. The CNA then moved onto another resident at the table. In addition, observation on 6/16/15 at 11:56 AM showed the resident had long facial hair on the upper lip and chin. Observation on 6/18/15 at 4:40 PM showed the resident continued to have long facial hair on the upper lip and chin. 4. Review of the 3/25/15 quarterly MDS assessment showed resident #48 required extensive assistance with dressing and personal hygiene. Observation on 6/15/15 at 11:40 AM revealed the resident's fingernails on both hands had crusted dark colored matter underneath the long nails. Observation on 6/18/15 at 11:04 AM showed the dark colored matter remained, and interview with CNA #1 at that time verified the nails were unclean and should have been cleaned on the resident's shower days. Interview with shower aide #1 on 6/18/15 at 11:05 AM verified the resident's nails were not cleaned on 6/10/15 when last showered. 5. Review of the 6/3/15 quarterly MDS assessment showed resident #63 required limited assistance with one person physical assistance	F 312	(QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date of Compliance 7/23/15	

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F 312	Continued From page 31 for personal hygiene, and extensive assistance for bathing. Observation on 6/15/15 at 3:25 PM revealed the resident's fingernails were soiled with dark colored matter around the nail beds and several nails were broken and jagged. Observation on 6/18/15 at 5:03 PM showed the resident's nails remained in the same condition. At that time CNA #2 verified the nails needed to be cleaned and trimmed. 6. Review of the quarterly MDS assessment dated 4/10/15 showed resident #72 had diagnoses including dementia. Further review showed the resident required extensive assistance for personal hygiene and bathing. Observation on 6/17/15 at 8:44 AM revealed the resident had thick white facial hair on the chin. Observation on 6/18/15 at 4:40 PM showed the resident continued to have thick white facial hair. 7. Review of the quarterly MDS assessment dated 1/31/15 showed resident #13 had diagnoses including dementia and had a BIMS score of 3/15 (severe cognitive impairment). Further review showed s/he required encouragement and cueing for personal hygiene. Observation on 6/15/15 at 11 AM showed the resident had long white facial hair on the chin. Observation on 6/18/15 at 4:40 PM revealed the resident continued to have long white facial hair on the chin. 8. Review of the quarterly MDS assessment dated 6/4/15 showed resident #85 had diagnoses including depression and required extensive assistance with bathing. Observation on 6/15/15 at 9:40 AM showed the resident had long jagged finger nails with brown grime accumulated underneath the nails. Observation on 6/17/15 at	F 312		

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F 312	Continued From page 32 8:50 AM revealed the resident continued to have long jagged fingernails with brown grime accumulated underneath the nails. 9. Review of the quarterly MDS assessment dated 4/23/15 showed resident #38 had diagnoses including dementia and hemiplegia, and required extensive assistance with bathing. Observation on 6/15/15 at 11 AM showed the resident had brown grime accumulated underneath the fingernails. Observation on 6/18/15 at 4:40 PM revealed the resident continued to have brown grime accumulated underneath the fingernails. 10. Interview on 6/18/15 at 4:40 PM with CNA #6 confirmed the nails and facial hair for residents #13, #38, and #72 were noticeable and should have been addressed. She further revealed nail care and facial hair grooming "should be done in the shower" routinely.	F 312	F 314 – Pressure Ulcers Corrective Action The DON/Designee have reviewed the care plan interventions related to wound care for resident #12 on 6/17, 7/4, & 7/17/15. New treatment orders were obtained on 6/17/15, 6/26/15, 7/9/15, & 7/17/15. ID of Others The Director of Nursing or designee will review care plan interventions for residents with wounds and update as needed. CNA assignment sheets will be updated to reflect interventions as appropriate. Systemic Change	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review	F 314	The Staff Development Coordinator or designee will educate nursing staff on interventions to promote wound healing and following care plans. Nursing management will conduct random rounds three times per week on residents with significant wounds to ensure care plan interventions are followed, including incontinence management and positioning. Monitoring The Director of Nursing or designee will conduct wound management audits weekly to check that components of the Skin Management	

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F 314	Continued From page 33 and staff interview, the facility failed to implement interventions to promote healing and prevent avoidable worsening of pressure ulcers. This failure resulted in a negative outcome for 1 of 2 sample residents (#12) with pressure ulcers. The findings were: 1. Review of the 4/13/15 significant change MDS assessment showed resident #12 required the extensive assistance of two persons for ADLs including bed mobility, dressing, and toilet use, and was totally dependent on the assistance of two persons for transfers. Further, the assessment showed the resident had an unstageable pressure ulcer that measured 4 cm by 4 cm. Review of weekly pressure ulcer records showed an unstageable pressure ulcer, located on the resident's left ishium, was identified on 4/1/15. At that time, the ulcer measured 4 cm by 4 cm. Review of the resident's care plan for incontinence, updated 6/17/15, showed the resident was to be checked and changed every 2 hours. Review of the resident's care plan for pressure ulcers, last reviewed on 6/17/15, showed the resident was to have "rest periods in bed between meals." The following concerns were identified: a. Review of the 3/15/15 SBAR (Situation Background Assessment Recommendation) communication form showed the resident had developed a previous open area to the buttocks. "Not laying resident down after each meal" was listed as something that made the condition worse, and "laying resident down after each meal" was listed as something that made the condition better. b. Review of the 3/26/15 SBAR communication form showed the resident developed a "2.5 cm reddish area to L [left] lower	F 314	system are in place. The audit will include observations to check that care plan interventions are being followed. Corrective actions will be taken as needed. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date of Compliance 7/23/15	

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F 314	Continued From page 34 buttock." "Positioning" was listed as something that made the condition worse and better. Additionally, the communication form noted the resident needed to be repositioned every 2 hours. c. Review of the 4/8/15 nursing weekly/monthly summary showed "...Pressure ulcer is now a stage II 4.0 X [by] 4.0 ulcer left ishium. Air mattress is on bed, with frequent turning, keeping [resident] dry with every 2 hour check and change...and [resident] lies down between meals to relief (sic) pain pressure on ischial tuberosity..." d. Review of the 5/29/15 weekly pressure ulcer record showed the pressure ulcer to the left ishium had increased in size to 4.8 by 5.2 cm, had a large amount of purulent exudate, and the resident was being referred to a wound clinic for treatment. e. Review of 6/4/15 wound clinic documentation showed the ulcer had a large amount of drainage, had a foul odor, and measured 5.0 by 5.0 cm, with a depth of 1.5 cm. Physician orders from the wound clinic, dated 6/5/15, included "Keep pressure off wound at all times." f. Review of 6/16/15 wound clinic documentation showed the wound's healing progress was unchanged. Instructions from the wound clinic included "Nurses to keep Pt [patient] off wound area left buttock area." g. Continuous observation on 6/18/15 beginning at 9:47 AM showed the resident was up in his/her wheelchair, sitting in the front area near the facility entrance. At 10 AM, the resident was taken back to the activity room. The resident was not checked for incontinence, or repositioned. The resident's participation in the activity was minimal. At 10:43 AM, the resident was wheeled back to the front area near the facility entrance	F 314		

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F 314	Continued From page 35 and left there. The resident was not checked for incontinence or repositioned. At 11:15 AM, the resident was again taken to the activity room, which also functioned as a dining room for meals, and was not checked for incontinence or repositioned. At 1:08 PM, (3 hours and 21 minutes after the observation began) the resident was taken to his/her room and laid down in bed. The resident's incontinence brief was changed at that time, and CNA #3 revealed the brief was wet. h. Interview with CNA #3 on 6/18/15 at 1:13 PM confirmed that was the first time the resident had been laid down or checked for incontinence since "we got [him/her] up for breakfast." Review of posted facility dining times revealed breakfast was served at 7:30 AM. I. Interview with the facility administrator and corporate RN #1 on 6/18/15 at 6:45 PM confirmed the physician's order to keep pressure off of the resident's wound meant, in order to promote healing of the wound, the resident should not have been sitting up in a wheelchair for such a long period, and that s/he should have been checked for incontinence every two hours.	F 314	F 315 – Catheter Care, Prevention of UTI Corrective Action The Director of Nursing or designee will evaluate incontinence management for resident #12 and update care plan and assignment sheet as needed by the date of compliance. Routine care givers for resident #12 will be educated on incontinence interventions by the Staff Development Coordinator or designee by the date of compliance. ID of Others The Director of Nursing or designee will identify incontinent residents, evaluate interventions and update care plans and assignment sheet s as needed by the date of compliance.	
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.	F 315	Systemic Change The Staff Development Coordinator or designee will educate nursing staff on incontinence management and following the interventions in the incontinence care plan. The Ambassadors will conduct routine rounds with residents and if any concerns r/t incontinence or toileting are observed they will notify nursing management. Monitoring	

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F 315	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to provide necessary incontinence services for 1 of 7 sample residents (#12) with incontinence. The findings were: 1. Review of the 4/13/15 significant change MDS assessment showed resident #12 required the extensive assistance of two persons for toilet use, and was always incontinent of urine. Further, the assessment showed the resident had an unstageable pressure ulcer that measured 4 cm by 4 cm. Review of the resident's care plan for incontinence, updated 6/17/15, showed the resident was to be checked and changed every 2 hours. The following concerns were identified: a. Continuous observation on 6/18/15 beginning at 9:47 AM showed the resident was up in his/her wheelchair, sitting in the front area near the facility entrance. At 10 AM, the resident was taken back to the activity room. The resident was not checked for incontinence, or repositioned. The resident's participation in the activity was minimal. At 10:43 AM, the resident was wheeled back to the front area near the facility entrance and left there. The resident was not checked for incontinence or repositioned. At 11:15 AM, the resident was again taken to the activity room, which also functions as a dining room for meals, and was not checked for incontinence or repositioned. At 1:08 PM, (3 hours and 21 minutes after the observation began) the resident was taken to his/her room and laid down in bed. The resident's incontinence brief was changed at that time, and CNA #3 revealed the brief was wet. b. Interview with CNA #3 on 6/18/15 at 1:13	F 315	The Director of Nursing or designee will conduct random rounds three times a week to monitor if care plan interventions for incontinence are being followed. Corrective actions will be taken as needed. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date of Compliance 7/23/15	

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F 315	Continued From page 37 PM confirmed that was the first time the resident had been laid down or checked for incontinence on 6/18/15 since "we got [him/her] up for breakfast." Review of posted facility dining times revealed breakfast was served at 7:30 AM. c. Interview with the facility administrator and corporate RN #1 on 6/18/15 at 6:45 PM confirmed the resident should not have been sitting up in a wheelchair for such a long period, and that s/he should have been checked for incontinence every two hours.	F 315	F 328 – Treatment for Special Needs Corrective Action Resident #88's oxygen tank was filled by staff members as noted in the 2567. ID of Others The DON/Designee will conduct an audit of all portable oxygen tanks in the building to inspect for the presence of oxygen.	
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; 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, staff interview, and medical record review, the facility failed to ensure oxygen therapy was provided as needed for 1 of 5 sample residents (#88) who used oxygen therapy. The findings were: Review of the 6/11/15 annual MDS assessment showed resident #88 had diagnoses including chronic obstructive pulmonary disease, heart	F 328	Systemic Change Education will be provided to staff members by the DON/Designee on/before the date of compliance in regard to, but not limited to, proper ways to check an oxygen tank to confirm the presence of oxygen. Staff members are educated to check on oxygen levels during cares. Monitoring The DON/Designee will conduct random audits of portable oxygen tank levels weekly and review those audits for trends. Corrective action will be taken as needed. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued	

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F 328	Continued From page 38 failure, and dementia. Review of the doctor's progress note dated 6/4/15 showed an additional diagnosis of hemoptysis (coughing up blood) and bronchitis. Review of a physician telephone order dated 5/3/15 at 3 PM showed an order for "O2 [oxygen] therapy as needed to maintain SATS [saturation levels] greater than 90%." Continuous observation on 6/15/15 beginning at 3:15 PM showed resident #88 sitting at a table immediately following an activity, with a nasal cannula in place and an oxygen tank hanging from the back of the wheelchair. The dial on the oxygen tank was observed to show "empty." At 3:20 PM, the resident removed the nasal cannula from his/her nose and played with it before letting it drop to the side of the wheelchair. The following concerns were identified: a. At 4:12 PM, CNA #2 provided the resident with a magazine, but did not assist with replacing the nasal cannula on the resident's nose or check the oxygen level of the tank. b. At 4:50 PM, the resident self-propelled the wheelchair down the hall. At 4:55 PM, CNA #8 noticed the oxygen tubing hanging from the side of the wheelchair, disconnected the tubing from the resident's tank, replaced it with new tubing, but did not check the oxygen level of the tank at that time. c. At 5 PM, CNA #7 pushed the resident in the wheelchair down the hall toward the dining room for dinner when the resident requested to use the toilet. RN #2 assisted the resident in the bathroom at 5:09 PM and checked the oxygen tank (1 hour and 54 minutes after originally observed on empty). Interview with the nurse at that time verified that the tank was "completely empty."	F 328	compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date of Compliance 7/23/15	
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329	F 329 – Unnecessary Medications Corrective Action The pharmacy consultant and the attending physician will review the antipsychotic and antidepressant medications for resident # 87. A Gradual Dose Reduction was requested for Resident #87 on each of the 5 medications referenced. If medications are not reduced a risk / benefit statement will be provided. A Psychoactive Medication Evaluation form has been completed and behavior monitoring sheet has been initiated for the psychoactive medications and antidepressants. ID of Others An audit of psychoactive medications, including gradual dose reductions and / or risk benefit statements, behavior monitoring sheets and quarterly evaluations, will be completed by the social Service director or designee by the date of compliance. Corrective actions will be taken as needed.	

Systemic Change

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F 329 SS=D	Continued From page 39 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interview, the facility failed to ensure the drug regimen was free of unnecessary medications for 1 of 17 sample residents (#87). The findings were: 1. Review of the medical record showed resident #87 was admitted to the facility on 10/21/14 with diagnoses of hypothyroidism, glaucoma, hearing	F 329	The Interdisciplinary team will be educated by the District Director of Clinical Services or designee by the date of compliance on facility Psychoactive Medication Management protocols. The facility will begin conducting weekly Psychoactive Medication Meetings with the assistance of a consultant Social Worker. The purpose of the meeting is to review current medication regimes for residents receiving psychoactive medications. Residents on psychoactive medications will be reviewed upon admission, with changes in medications and quarterly per MDS schedule. An audit of psychoactive medications will be completed in conjunction with the weekly meeting. The audit will include gradual dose reduction and / or risk benefit statements, behavior monitoring forms, and quarterly completion of psychoactive evaluation form. Monitoring The Director of Nursing or designee will complete random audit of psychoactive medications weekly for 3 months. Corrective actions will be taken as needed.	

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F 329	Continued From page 40 loss, history of fall, anxiety disorder, blindness/low vision, and arthropathy. Review of the June 2015 MAR showed the resident was receiving the following medications: -Trazodone (an antidepressant) 25 mg daily at 8 PM started on 10/21/14 -Seroquel (an antipsychotic) 75 mg twice daily at 8 AM and 8 PM with a start date of 2/14/15, and a 50 mg dose to be given at 2 PM started on 2/19/15 -Remeron (an antidepressant) 15 mg daily at 8 PM started on 3/6/15 -Abilify (an antipsychotic) 2mg daily at 8 AM with a start date of 4/8/15 -Zoloft (an antidepressant) 50 mg daily at 8 AM with start date of 4/17/15 Review of the 11/18/14 admission MDS assessment showed the resident had a BIMS score of 12/15 (moderately impaired 8-12). Review of the 2/25/15 quarterly MDS assessment showed a decline in the BIMS score to 8/15. Review of the 4/14/15 quarterly MDS assessment showed 5 months after admission the resident had further declined in cognition to a BIMS score of 3/15 (severely impaired 0-7). The following concerns were identified: a. Review of the medical record failed to show documented clinical rationale for the benefit of, or necessity for, the use of multiple medications from the same pharmacological class (2 antipsychotics and 3 antidepressants). b. Review of the medical record showed there were no nurses' notes or other notes with evaluations of these medications since the evaluations titled "Psychoactive Medication Evaluation" which were dated 4/9/15. The evaluation for the use of Seroquel showed the	F 329	The results of the weekly meetings will be brought to QAPI by the SSD to show progress in the system as well as examine trends. The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date of Compliance 7/23/15	

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F 329	Continued From page 41 behaviors that warranted use of the medication were "hitting, yelling, repetitive statements, attempting to call others." The evaluation showed these behavioral episodes occurred daily. The recommendation was "GDR [gradual dose reduction] requested." Review of the medical record and monthly MARs failed to show any evidence of behavioral monitoring related to these distressed behaviors. Further, there was no evidence a GDR was attempted. c. The 4/9/15 evaluation of the Remeron showed it was used to treat yelling, trouble sleeping, hitting and aggression. These behaviors were shown as a daily frequency. Review of the medical record and monthly MARs failed to show any behavioral monitoring related to these distressed behaviors. d. Review of the 4/9/15 evaluation for the antidepressant Trazodone showed the medication was used to treat daily episodes of sadness, self-isolation, agitation, and sleeplessness. Review of the medical record and monthly MARs failed to show any behavioral monitoring related to these distressed behaviors. e. Review of the 4/9/15 evaluation for Zolft showed it was used to treat daily episodes of sadness, self-isolation, yelling and agitation. Review of the medical record and monthly MARs failed to show any behavioral monitoring related to these distressed behaviors. f. Review of the 4/9/15 evaluation for the use of Abilify showed it was used to treat daily excessive talking and excitability. Review of the medical record and monthly MARs failed to show any behavioral monitoring related to these distressed behaviors. g. Review of the Psychiatry follow-up notes showed the resident was seen on 12/30/14, 1/13/15, 2/3/15, 3/3/15, 4/7/15, 4/13/15 and	F 329		

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F 329	Continued From page 42 6/10/15. Review of the notes showed the resident had depression and anxiety related to being in the nursing home and separation from his/her son. The notes referred to the use of these medications; however, failed to include evidence of the distressed behaviors or clinical contraindication for dose reductions. h. Interview with corporate RN #1 on 6/18/15 at 7:50 PM verified additional behavior monitoring documentation could not be located related to the continued use of these medications. Additionally, the clinical rational for the use of multiple medications in the same classification was not able to be found.	F 329	F 367 – Therapeutic Diets Corrective Action Resident #2 is now receiving the proper diet as ordered Resident #11 is now receiving the proper diet as ordered Resident #48 is now receiving the proper diet as ordered Resident #69 is now receiving the proper diet as ordered Resident #70 is now receiving the proper diet as ordered	
F 367 SS=E	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of recipe instructions, diet order information, medical record review and review of the diet manual, the facility failed to ensure the therapeutic diet plan was followed for 5 of 5 sample residents (#2, #11, #48, #69, #70) and 21 non-sample residents (#1, #4, #5, #9, #10, #17, #19, #21, #22, #25, #40, #43, #50, #57, #61, #68, #72, #74, #82, #95, #99) who had therapeutic diets. The findings were: Review of the diet order list printed on 6/17/15 showed residents #1, #2, #4, #5, #9, #10, #11, #17, #19, #21, #22, #25, #40, #43, #48, #50, #57, #61, #68, #69, #70, #72, #74, #82, #95, #99 had	F 367	Resident #1 is now receiving the proper diet as ordered Resident #4 is now receiving the proper diet as ordered Resident #5 is now receiving the proper diet as ordered Resident #9 is now receiving the proper diet as ordered Resident #10 is now receiving the proper diet as ordered Resident #17 is now receiving the proper diet as ordered Resident #19 is now receiving the proper diet as ordered Resident #21 is now receiving the proper diet as ordered Resident #22 is now receiving the proper diet as ordered Resident #40 is now receiving the proper diet as ordered Resident #43 is now receiving the proper diet as ordered	

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F 367	Continued From page 43 physician orders for a ground/mechanical soft diet texture. In addition, residents #1, #10, #40, #69, #74, #82, #99 had orders for thickened liquids. The following concerns were identified: a. Observation of the 6/15/15 noon meal service showed the cut steamed broccoli was served to residents with mechanical soft diet orders without any chopping or further modification. The broccoli was noted to be large pieces of flowerets and also 1/2 to 1 inch long pieces of the stems. In addition, the dinner roll served for the meal did not include any additional moisture, the roll was observed to have a tough crust on the top. b. Review of the facility's recipe instructions showed the "broccoli cuts" were not to be served for the mechanical soft consistency. Rather chopped or sliced broccoli was to be substituted. c. Observation on 6/16/15 at 5:11 PM showed resident #69 was served three meatballs, rather than the ground texture meatballs which were available. d. Observation on 6/17/15 at 5:50 PM showed resident #69 had been served vegetable soup which consisted of cut vegetables in a thin broth which was not thickened, and also had a glass of ice water which was not thickened. e. Observation on 6/17/15 at 5:50 PM during the evening meal service showed the soup served to residents was all of the same thin broth regular diet consistency. Interview with the registered dietitian (RD) and dietary manager on 6/18/15 at 12:30 PM verified the soup was of a thin broth consistency and not thickened. f. Review of the facility's diet manual resource: Healthcare Services Group, Inc. Diet Manual Third Edition 2011, showed breads and rolls with dry hard crust was not allowed for mechanical soft diets. In addition, the diet manual	F 367	Resident #50 is now receiving the proper diet as ordered Resident #57 is now receiving the proper diet as ordered Resident #61 is now receiving the proper diet as ordered Resident #68 is now receiving the proper diet as ordered Resident #72 is now receiving the proper diet as ordered Resident #74 is now receiving the proper diet as ordered Resident #82 is now receiving the proper diet as ordered Resident #95 is now receiving the proper diet as ordered Resident #99 is now receiving the proper diet as ordered ID of Others Facility NHA/Designee will monitor 5 random meals before the date of Compliance to inspect for proper textures and proper liquids per the resident tray card. Any concerns identified will be corrected prior to the tray being served to the resident. The Dietary Manager or designee will audit tray cards for correct diet and thickened liquid orders by the date of compliance Corrective actions will be taken as needed. Systemic Change	

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F 367	Continued From page 44 showed large vegetables such as broccoli or cauliflower should be chopped or sliced. g. Interview with the RD and the dietary manager on 6/17/15 at 3:22 PM verified the cooks and servers needed to be aware and serve the diet as ordered and in the appropriate size and consistency. The RD verified the dietary staff were provided education related to modified diets in orientation. However, there was nothing documented and a routine or formal education on the subject was lacking. In addition, the dietary manager verified the computerized system which contained the menu recipes and instructions was not accessible by the cooks. Further, this information was not provided in a format that was available in the kitchen for production purposes.	F 367	Education will be provided on/before the date of compliance to the Dining Staff by the Dietary General Manager in regard to the requirements for each Diet Type that the home serves. The education provided will be maintained in the kitchen for reference of the dining staff members. The Staff Development Coordinator or designee will educate staff members on reading tray card when serving tray to ensure proper diet is served. Monitoring The NHA/Designee will monitor 3 meals weekly for 12 weeks and review the results of each meal observed to help improve the meal delivery system. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date of Compliance 7/23/15	
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 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure food was properly stored, that equipment was clean, and that wet wiping clothes were held in sanitizer solution. The findings were:	F 371	F 371 Corrective Action	

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F 371	Continued From page 45 1. Observation on 6/15/15 at 9:14 AM showed various unlabeled or expired items available in the reach in refrigerator. These included: a. A container of "Pork loin" dated "use by 6/12". b. A pan of what appeared to be brown gravy with no label or date. c. A small container of "sliced turkey" with no date. d. Marinara sauce in a large container labeled "use by 6/14". e. 3 partial packages of sliced cheese with no dates. f. Cooked macaroni in a container with no date, the contents appeared to be spoiled with a slimy liquid in the bottom of the container. According to Food Code 2013, U.S. Public Health Service: 3-501.17 "(A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in ¶¶ (D) and (E) of this section, refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days. 2. Observation on 6/15/15 at 9:14 AM and 6/16/15 at 4:55 PM showed the exteriors including the handles of the refrigeration and freezer storage units were soiled with grime and sticky food residues. These included the 3 units near the back door and the freezer and	F 371	The food items noted in the 2567 were discarded during the survey as listed. The fridge and freezer units were properly cleaned. The facility ovens were properly cleaned. ID of Others The NHA/Designee will conduct an audit of the kitchen food storage for expired items or items not labeled/dated properly. Additionally the NHA/Designee will review the cleanliness of the kitchen equipment. Issues will be corrected as identified. Systemic Change Education will be provided on/before the date of compliance by the GM/Designee for the Dining Staff. The education will include, but not be limited to; Proper Labeling of food products, food storage timelines and requirements as well as cleaning of kitchen equipment. The facility will adhere to the current cleaning schedule to ensure compliance. The GM/designee will provide a daily informal review of the kitchen environment. Monitoring The NHA/Designee will inspect the kitchen weekly for proper food storage	

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F 371	Continued From page 46 refrigerator unit on the south wall. In addition, the interior and exterior of the 2 ovens and the top convection oven were soiled with grease and food bulid-up which needed to be cleaned. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 3. Observation on 6/15/15 at 9:25 AM showed a cutting board and knife located on the food preparation table. There was no food on the table at that time, however, there were three wet wiping cloths on the table. According to Food Code 2013, U.S. Public Health Service, 3-304.14: "(B) Cloths in-use for wiping counters and other EQUIPMENT surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under § 4-501.114;" 4. Interview with the registered dietitian and the dietary manager on 6/18/15 at 3:15 PM revealed the kitchen needed more frequent cleaning and a deep cleaning list was being developed. The expired/spoiled food items had been discarded and the dietary manager verified the need for proper labels and dates for all items.	F 371	as well as inspecting for properly cleaned surfaces. The results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date of Compliance 7/23/15	
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS	F 386	F 386 – Physician Visit Documentation Corrective Action The notes for Resident #54 were received in the facility during the survey and placed in the medical record. ID of Others The facility Health Information Manager (HIM)/Designee will conduct an audit of all current resident charts to inspect for physician visit notes for the past 6 months. If notes are found to be missing they will be requested and placed in the medical record.	

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F 386	Continued From page 47 The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure physician progress notes were available in the medical record for 1 of 17 (#54) sample residents. The findings were: Medical record review showed resident #54 was admitted to the facility on 5/24/11. The review revealed there were no physician progress notes in the record since 12/3/14 and no documentation to show physician visits since that time. On 6/17/15 at 11 AM the administrator provided physician progress notes for 1/26/15, 2/26/15, 3/17/15, 4/28/15, and 5/26/15. Interview at that time revealed the facility acquired the progress notes on 6/17/15 via fax from the physician's office, and the notes had not been available at the facility prior to that.	F 386	The facility made a change in the position of HIM in late May. The new HIM started on 6/15/15, the first day of the survey. Education will be provided by the DON/Designee to the current HIM on/before the date of compliance in regard to the importance of proper filling of such visit records. Monitoring The HIM/Designee will complete and audit monthly to inspect that the most recent visit notes are present in the chart. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance.	
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	F 441	Date of Compliance 7/23/15 F 441 – Infection Control Corrective Action Resident #94 has been placed on contact precautions. The care plan has been updated to reflect the contact precautions. Routine caregivers will be educated on the care plan	

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F 441	Continued From page 48 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of facility policy and procedure, and staff interview, the facility failed to implement infection control procedures to prevent the spread of	F 441	interventions for the current infection for resident #94 by the Director of Nursing or designee. A sign stating that "Any Visitors Must Visit the Nurses Station Prior to Entering the Room" was hung on the resident's door. ID of Others The DON/Designee will review all residents with communicable diseases requiring to ensure that proper infection control precautions are in place. Staff will be educated as needed. Corrective actions will be taken as needed. Systemic Change Education will be provided to Staff members on/before the date of compliance in regard to the proper requirements needed for Isolation Precautions and when someone should be placed on precautions. The education will include that signage will be used to alert staff members to the changes in a residents care needs. Signage on the resident room will alert staff members to the precaution. During daily clinical meeting, lab results, new orders for antibiotics and new infections will be reviewed by Infection Control Nurse or designee. The infection control nurse will	

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F 441	Continued From page 49 disease for 1 of 1 sample residents (#94) with a communicable disease. The findings were: Review of the 3/24/15 admission MDS assessment showed resident #94 was admitted to the facility with a stage IV pressure ulcer. Review of the 6/10/15 lower coccyx wound culture result showed methicillin resistant Staphylococcus aureus (MRSA) was identified. Review of the resident's care plan for infection, dated 6/11/15, showed the resident was on contact isolation precautions. Review of the 6/12/15 nursing daily skilled summary showed "Continue contact iso [isolation] related to reported wound culture..." The following concerns were identified: 1. Review of the facility's policy for contact precautions (2012 ICP Associates, Inc.), revealed "VI. Contact precautions may be considered for (examples): A. Multi-drug resistant organisms (e.g., MRSA...)." Further review showed "III. Gowns. A. A gown should be donned prior to entering the room or resident's cubicle. B. The gown should be removed before leaving the resident's room. C. After removal of the gown, clothing should not contact potentially contaminated environmental surfaces." 2. Observation of the resident's room on 6/17/15 at 12:05 PM showed nothing posted on the door or in the area to indicate the resident was on contact precautions, or that persons entering the room should consult the nurse. There was no personal protective equipment (PPE), such as gloves or gowns, placed near the door. 3. Observation on 6/17/15 at 1:01 PM showed LPN #1 entered the room to check on the	F 441	evaluate interventions and amend as needed. When someone is placed on isolation precautions staff who routinely provide care to the resident will be educated on precautions to be initiated and reason for precautions by the Infection Control Nurse or designee. The infection control Nurse or designee will complete observation rounds 3 times per week of resident on isolation precautions. Corrective actions will be taken for any identified concerns. Monitoring The Infection Control Nurse or designee will review residents on a weekly basis to ensure that those residents requiring isolation precautions have them in place. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date of Compliance 7/23/15	

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F 441	Continued From page 50 resident and tell the resident that aides would be in shortly to assist him/her. The LPN then left the room, telling the resident "I'll be right back, I have to get some gloves." The LPN returned with gloves a short time later. 4. Observation on 6/17/15 beginning at 1:12 PM showed CNA #4 entered the resident's room, washed her hands and donned gloves, but did not don a disposable gown. She raised the resident's bed and used a pull sheet to position the resident onto his/her left side. CNA #5 entered the room at 1:16 PM, washed her hands and donned gloves, but did not don a disposable gown. The two aides proceeded to provide personal care to the resident, included emptying the resident's colostomy bag, emptying the resident's urine collection bag, cleaning the resident and repositioning the resident. CNA #4 was noted to rub the bottom of her nose with her gloved hands twice while providing care to the resident. The aides finished providing care to the resident, and then removed the trash in a regular trash bag. 5. Interview with CNA #4 on 6/17/16 at 1:25 PM revealed she was unaware the resident was on isolation precautions. 6. Interview with CNA #5 on 6/17/15 at 1:18 PM revealed she believed "the resident was still on contact precautions." 7. Interview with corporate RN #1 on 6/18/15 at 6:45 PM confirmed the resident's room should have been posted as requiring contact precautions, PPE should have been readily available, and all staff providing care to the resident should have been educated on contact precautions.	F 441		

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F 507 SS=D	483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to file resident laboratory test reports in the clinical record for 3 of 17 sample residents (#3, #18, #94). The findings were: 1. Review of the medical record for resident #3 showed a telephone order dated 5/14/15 for a complete blood count, comprehensive metabolic panel, and lipids to be done on 5/18/15. Further review of the clinical record showed no evidence these tests had been completed. Test results provided by corporate RN #1 on 6/18/15 at 4 PM confirmed the tests were completed, and interview at that time confirmed the results had not been filed in the resident's clinical record. 2. Review of the medical record for resident #18 showed the following: a. A telephone order dated 4/24/15 for a basic metabolic panel to be done on 4/27/15. b. A telephone order dated 5/1/15 for a urinalysis with culture and sensitivity to be done on 5/4/15. c. A telephone order dated 1/26/15 for a basic metabolic panel to be done on 2/2/15. Further review of the medical record showed no evidence these tests had been completed. Test	F 507	F 507 – Lab Reports not present in the Chart Corrective Action The lab results for resident #3's labs were placed in the chart during the survey. The lab results for resident #18's labs were placed in the chart during the survey. The lab results for resident #94's labs were placed in the chart during the survey. ID of Others The HIM/Designee will audit the past 60 days of Physician orders and Medical records for any diagnostic tests & results to ensure that all of those requests have been properly completed and filed. Systemic Change Education will be provided on/before the date of compliance to the HIM by the DON/Designee in regard to the timeline and process for information to be filed in the residents chart. Education will be provided to the licensed nurses by the Director of Nursing or designee by the date of compliance on the process for ordering and obtaining results for labs, x-rays and other tests.	

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F 507	Continued From page 52 results provided by corporate RN #1 on 6/18/15 at 4 PM confirmed the tests were completed, and interview at that time confirmed the results had not been filed in the resident's clinical record. 3. Review of the 5/27/15 report of consultation for resident #94 showed a culture and sensitivity was ordered on the resident's wound. Further review of the clinical record showed no evidence this culture and sensitivity was completed. Test results provided by corporate RN #1 on 6/18/15 at 4 PM confirmed the culture and sensitivity had been completed, and interview at that time confirmed the results had not been filed in the resident's clinical record.	F 507	During daily clinical meeting orders for labs will be reviewed for completion and presence of results in the medical record. Monitoring The DON/Designee will conduct an audit of labs weekly for weeks and then monthly for 2 months to ensure that the labs results are received and placed in the chart timely. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date of Compliance 7/23/15	
F 508 SS=D	483.75(k)(1) PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure radiology and diagnostic procedures were completed for 1 of 5 sample residents (#84) with these types of procedures ordered. The findings were: Review of the medical record showed resident #84 had diagnoses including hypertension, schizophrenia, and bipolar disorder. Review of the physician's "report of consultation" documentation dated 5/11/15 showed the following recommendations: "1. I have requested	F 508	F 508 – Radiology Results Corrective Action The EKG was completed for Resident #84 ID of Others The HIM/Designee will audit the past 60 days of Physician orders and Medical records for any diagnostic tests & results to ensure that all of	

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F 508	Continued From page 53 an EKG on [resident] 8/19/14, 2/19/15, and 3/30/15. I have never received these results..." Review of the electrocardiogram order, dated 8/27/15, showed an EKG was ordered by the medical director. There was no documentation in the medical record of additional EKG orders or results. Telephone interview with the administrator on 6/24/15 at 10:15 AM verified there was no evidence the ordered EKG was completed.	F 508	those requests have been properly completed and filed. Systemic Change The DON/Designee will provide education on/before the date of compliance to Licensed Nursing staff members in regard to the proper process to receive orders and setup the appointment or procedure. During daily clinical meeting orders for EKG's will be reviewed for completion and prescence of results in medical record. Monitoring The DON/Designee will audit EKG requests weekly for 4 weeks and monthly for 2 months to ensure that all EKG's are properly completed. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date of Compliance 7/23/15	
F 513 SS=E	483.75(k)(2)(iv) X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure radiology reports were filed in the medical record for 3 of 3 sample residents (#3, #18, #69) with radiology reports. The findings were: 1. Medical record review showed an order dated 2/28/15 for resident #69 to receive an x-ray of the left hand related to a fall. Continued review of the record failed to show the results of this radiology procedure. Interview with the administrator on 6/17/15 at 10:35 AM verified the results of the x-ray were not in the record. The results were obtained and filed in the record on 6/17/15. 2. Review of the medical record for resident #3 showed a telephone order dated 6/9/15 for a cervical-spine x-ray. Further review of the clinical	F 513	F513 Signed and Dated Diagnostic Report	

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F 513	Continued From page 54 record showed no evidence this test had been completed. Test results provided by corporate RN #1 on 6/18/15 at 4 PM confirmed the tests were completed, and interview at that time confirmed the results had not been filed in the resident's clinical record. 3. Review of the medical record for resident #18 showed a telephone order dated 3/26/15 for a magnetic resonance imaging cervical-spine without contrast, and a telephone order dated 5/1/15 for computerized axial tomography of the head without contrast. Further review of the clinical record showed no evidence these tests had been completed. Test results provided by corporate RN #1 on 6/18/15 at 4 PM confirmed the tests were completed, and interview at that time confirmed the results had not been filed in the resident's clinical record.	F 513	Corrective Action The X-ray results for resident #69 were placed in the chart during the survey. The X-ray results for resident #3 were placed in the chart. The MRI results for resident #18 were placed in the chart. ID of Others The HIM/Designee will audit the past 60 days of Physician orders and Medical records for any diagnostic tests & results to ensure that all of those requests have been properly completed and filed. Systemic Change Education will be provided on/before the date of compliance by the DON/Designee to the Licensed Nursing Staff in regard to the proper protocol for receiving the order and arranging the service. During daily clinical meeting orders for XRays and MRI's will be reviewed for completion and presence of orders in chart. Monitoring The DON/Designee will audit Xray and MRI requests weekly for 4 weeks and monthly for 2 months. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for	
F 516 SS=E	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use. This REQUIREMENT is not met as evidenced	F 516		

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F 516	Continued From page 55 by: Based on observation and staff interview, the facility failed to safeguard medical records against unauthorized use in 1 of 3 record storage areas (the medical records office). The findings were: Observation of the medical record office on 6/17/15 at 11:10 AM showed there were 12 boxes of unsecured medical records on the floor. Other medical records were stored along the walls in open lateral file cabinets. Interview at that time with the medical records manager revealed the records were not secured within the room. At the end of her work day the main door was locked. However, in addition to herself, the DON, MDS coordinator, administrator, and maintenance director had keys to the room. With the maintenance director having access to the room, the facility failed to ensure only those with a need to know the information had access to the records.	F 516	3 months then reassess the need for continued monitoring based on compliance. Date of Compliance 7/23/15 F 516 Corrective Action The 12 boxes were removed from improper storage. The facility sent excess files that were appropriate for offsite storage to the Iron Mountain Facility. The facility was then able to properly secure all of the medical records within the medical records office. Access to the Medical Records has been limited to the Health Information Manager, Director of Nursing and Resident Director of Care Management.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of	F 520	ID of Others The NHA/Designee conducted an audit of the facility premises to inspect for any subsequent areas of improper record storage. Systemic Change Education will be provided by the NHA/Designee to the HIM in regard to proper storage of files and the need for proper levels of security in order to safeguard resident information.	

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F 520	Continued From page 56 action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and compliance history information, the facility failed to ensure an effective quality assessment and assurance (QAA) program was being implemented to prevent repeat deficiencies (F241, F225, F312, F371) from previous surveys. The findings were: 1. Review of the Casper 3 report last updated on 6/5/15 showed the facility was cited for resident dignity issues (F241) on the 2/2011 and the 1/2012 recertification surveys. In addition, the facility was cited for F241 on the 3/19/15 compliant survey and dignity issues are being cited for the 6/18/15 current recertification survey. 2. Review of the 6/5/15 Casper 3 report showed the facility was cited for non-compliance with investigation and reporting of resident abuse allegations (F225) on the 1/2012 recertification survey. Additional non-compliance was cited for F225 on the 1/17/14 complaint investigation and remained out of compliance on the 3/20/14 revisit survey. The facility is also cited with non-compliance for these issues on the 6/18/15	F 520	Monitoring The NHA/Designee will audit the medical records office weekly for 4 weeks and monthly for 2 months to ensure all files are properly stored within the office. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date of Compliance 7/23/15 F 520 – Quality Assurance Corrective Action Repeat tags for 225 Abuse, 241 Dignity, 312 Dependent ADL Cares, 371 Kitchen Sanitation ID of Others Review of Current PIP's and Action Plans with the outgoing NHA. Systemic Change The Senior NHA/Designee will provide Education to the Facility Leadership team in regard to an effective and appropriate QAPI process.	

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F 520	Continued From page 57 recertification survey. 3. Review of the 6/5/15 Casper 3 report showed the facility was cited for not providing resident ADL assistance (F312) on the 2/2011 recertification survey. Review of complaint investigation reports showed the issues were also cited on the 1/2/15 and 3/19/15 complaint surveys. The facility was also found to be non-compliant with these requirements on the 6/18/15 recertification survey. 4. Review of the 6/5/15 Casper 3 report showed the facility was cited for food storage and kitchen sanitation issues (F371) during the 2/2011, 1/2013, and 3/20/14 recertification surveys. Non-compliance with the F371 requirements was also identified on the current 6/18/15 recertification survey. 5. Interview with the administrator on 6/18/15 at 5:15 PM verified the quality assurance process was not effective in all areas.	F 520	Monitoring The NHA/Designee will hold weekly QAPI meetings to ensure proper discussion and follow up or progress is being made in regard to the correction of the current deficiencies. The home will still conduct a Monthly QAPI meeting to review all issues in the home but will use the other meetings to focus on the currently outstanding tags. Results will be reported to the Quality Assurance Performance Improvement (QAPI). The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months then reassess the need for continued monitoring based on compliance. Date – 7/23/15	