STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING _____ B. WING _____	09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABI	3128 BOXELDER DRIVE CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 8/31/15 through 9/3/15. Also reviewed in the course of this survey were complaint intakes WY000002043, WY000002060, WY000002066, and WY000002091. The following common abbreviations are used throughout this document: ADLs: Activities of Daily Living CNA: Certified Nurse Aide DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000	F203 Corrective Action: Resident #85 was emergently discharged from the facility in March, as a result, proper discharge paperwork cannot currently be given. Verbal notice was given to the DPOA, upon discharge and noted in the medical record. Identification of Others: All discharged residents have the potential to be affected. Medical records of residents discharged from the facility in the last 30 days were reviewed by the Director of Social Services. All residents had the appropriate discharge paper work. System Changes: The Director of Social Services, will be re-educated by the ED or RDCO and provided with the proper documentation to use in the event of emergency discharge.	10/18/2015
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	F 203		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	9/28/15

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.

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F 203	Continued From page 1 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 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 notify the resident's family or legal representative of the discharge in writing and include all required items for 1 of 1 facility-initiated discharges reviewed (#85). The findings were: Review of the health status note dated 3/27/15,	F 203	Monitoring: A QA tool will be implemented by the Director of Social Services/Designee to ensure all residents/representatives receive written notification of transfer or discharge. This tool will be completed weekly and results reported to QA committee monthly x 3 months until a lesser frequency is recommended by the committee.	

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F 203	Continued From page 2 timed 11:12 AM, for resident #85 showed the resident was discharged from the facility on 3/27/15. Review of the health status note dated 3/26/15, timed 4:26 PM, showed the discharge was initiated by the facility. Further review of the medical record failed to show evidence the facility provided the resident's legal representative with a written discharge notice that included all required elements. Interview with the administrator on 9/3/15 at 3:50 PM confirmed no written discharge notice was provided to the resident's family or legal representative.	F 203	F225 Corrective Action: SDC verified certificates of CNA 4, 5, and 6 on the Wyoming state abuse registry, with no negative findings. All current CNAs have been checked on the nurse aide abuse registry. Identification of Others: The Staff Development Coordinator and/or Designee will conduct an audit of employee's files to confirm that all CNAs have been checked on the state registry. System Changes: The DNS provided education to all managers with hiring privileges. The facility will ensure that each new CNA applicant will be reviewed in the Wyoming State abuse registry prior to date of hire.	10/18/2015
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	F 225		

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F 225	Continued From page 3 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This Requirement is not met as evidenced by: Based on employee record review, staff interview, and review of the nurse aide abuse registry, the facility failed to check the nurse aide abuse registry for 3 of 3 CNAs (#4, #5, #6) reviewed. The findings were: 1. Review of the employee records for CNA #4 showed his date of hire was 3/16/15. Further review showed the CNA abuse registry was not checked until 9/2/15, approximately 5 1/2 months following the date of hire. 2. Review of the employee record for CNA #5 showed her date of hire was 4/20/15. Further, it showed the CNA abuse registry was not checked until 9/2/15, approximately 4 1/2 months following the date of hire. Further, review of the nurse aide abuse registry showed the CNA had not yet been placed in the system which showed: "No people meet the selected criteria." 3. Review of the employee record for CNA #6 showed her date of hire was 8/26/15. Further, it showed the CNA abuse registry was not checked until 9/2/15. Further, review of the nurse aide	F 225	Monitoring: A QA monitoring tool will be implemented by the SDC/Designee to ensure compliance with verification of certificates on the Wyoming State abuse registry for CNAs. This tool will be completed weekly with results to the QA committee monthly to identify trends, and will continue until a recommendation from the QA committee for a lesser frequency.	

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F 225	Continued From page 4 abuse registry showed the CNA had not yet been placed in the system which showed: "No people meet the selected criteria." 4. Interview with the staff development director on 9/2/15 at 6:30 PM, verified the CNA abuse registry was not checked when new CNAs were hired.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This Requirement is not met as evidenced by: Based on employee record review, staff interview, and review of policies and procedures, the facility failed to ensure in-service training related to abuse, neglect, and misappropriation of resident property was provided to 4 of 7 housekeeping employees (#1, #2, #3, #4) prior to initial contact with residents. The findings were: 1. Review of the policy and procedure entitled "Inservice Education/Training last dated 8/21/15 showed abuse and neglect training for employees was to include; "1) Appropriate interventions to deal with aggressive and/or catastrophic reactions of patients; 2) How to report their knowledge related to allegations; 3) How to recognize signs of burnout, frustration and stress that may lead to abuse; and 4) What constitutes abuse, neglect and misappropriation of patient property?" 2. Interview with housekeeper #1 on 9/1/15 at	F 226	F226 Corrective Action: Employees #1, #2, #3, and #4 have been provided training related to abuse, neglect, and misappropriation of resident property. Identification of Others: The Staff Development Coordinator and/or Designee will conduct an audit of employee's files to confirm that abuse, neglect, and misappropriation of resident property training has been provided to employees prior to initial contact with residents. System Changes: The Staff Development Coordinator and/or Designee will conduct an audit of new employee's files weekly for 90 days to confirm that abuse, neglect, and misappropriation of resident property training has been provided to	10/18/2015

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F 226	Continued From page 5 8:45 AM, revealed she had worked in the facility for 3 months and had not been provided abuse training at the time of hire. Further, she was uncertain what to do if she witnessed abuse. Review of her employee record failed to show she had received training related to abuse and neglect. 3. Review of the dates of hire for housekeeping employees #1, #2, #3, and #4 showed they began working for the facility between 6/5/15 and 7/6/15. Review of the Patient/Resident Abuse/Neglect In-Service report dated 9/1/15 showed these housekeeping employees were provided abuse and neglect training on that date. 4. Interview with the DON on 9/3/15 at 12 PM, revealed the housekeeping staff were contracted and she was not aware if they had the training at the time of hire. Further, during an interview at 6:25 PM that same day, the DON acknowledged all employees, including the housekeeping staff, needed training in abuse, neglect and misappropriation of resident property.	F 226	employees prior to initial contact with residents. Monitoring: A QA monitoring tool will be implemented by the SDC/Designee to ensure abuse, neglect, misappropriation training is completed on all employees including contractors, during orientation. The tool will be completed weekly(for 90 days) with results taken to monthly QA to identify trends until a lesser frequency is recommended by the committee.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This Requirement is not met as evidenced by: Based on observation, medical record review and staff and family interview, the facility failed to promote care for residents in a manner that maintains and enhances each resident's dignity for 1 of 14 sample residents (#33) and one randomly observed non-sample resident (#31).	F 241		

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F 241	Continued From page 6 The findings were: 1. Review of the 8/27/15 admission MDS assessment showed resident #31 required one-person assist with eating. Additionally, the care plan, initiated on 8/27/15, showed that the resident required "1 person staff participation" to eat. The following concerns were identified: a. Observation of the meal on 9/2/15 beginning at 12:57 PM showed the resident was served a piece of meat that was not already cut into small pieces and his/her hands were shaky when s/he tried to cut the meat. The resident's hand continued to shake when s/he reached for coffee and tried to take bites of food. By the end of the meal the resident had eaten an estimated 50% of the meat but left the roll and fries on the plate and did not drink any milk. At no point during the meal did a CNA or other staff member assist or offer to assist the resident with eating. b. Review of a progress note dated 8/18/15, timed 9:10 PM, indicated that the resident had trouble eating meals without assistance due to hand tremors that caused food to fall off utensils. c. Review of a progress note dated 8/20/15, timed 4:51 PM, showed the registered dietitian wrote an order to downgrade the resident's diet to a mechanical soft, finger food diet, due to the resident's inability to eat with utensils. d. Review of a progress note dated 8/21/15, timed 5:05 AM, revealed the need to change the resident's diet order to mechanical soft finger food with ground meats due to his/her inability to use utensils. e. Review of a progress note dated 8/24/15, timed 12 PM, showed the resident was consuming less than 25% of meals due to shaking. f. Review of a progress note dated 8/24/15, timed 6:01 PM, showed the resident ate in the	F 241	F241 Corrective Action: Resident #31 was reassessed to determine proper assistance during meals. Resident # 33 was assisted to the restroom. Identification of Others: The Director of Nurses/Designee will conduct a facility-wide audit to confirm that residents are being provided the appropriate and necessary services at meals. The Director of Nurses/Designee will conduct a facility-wide audit to confirm that residents are being responded to in a timely manner and they are provided the required toileting services. System Changes: SDC will re-educate nursing staff on assisting residents during meal times,	10/18/2015

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F 241	Continued From page 7 dining room as an assisted diner with poor intake. g. Review of a progress note dated 9/2/15, timed 6:08 PM, showed the resident continued to struggle with self-feeding and "needs assistance during meal-time." h. Review of the 8/24/15 Nutritional Status Care Area Assessment worksheet showed "Res [Resident] states that [s/he] is 'hungry as heck' but has decreased dietary intake d/t [due to] difficulty self-feeding; unable to hold utensils d/t [due to] shaking, does better w/ [with] finger foods; enjoys food & house supp [supplement]; states that [his/her] current wt [weight] is not unusual for [him/her], that [s/he] thinks [s/he] should weigh 20-30 lb [pounds] more ...Res has poor dietary intake d/t difficulty self-feeding ....Res reports enjoying the food & having a good appetite, and wishes [s/he] could eat more easily ... " i. Interview with the resident's family member on 8/31/15 at 10:05 AM revealed they believed the resident was having difficulty feeding [himself/herself] and was not getting enough to eat. j. During interview with the DON on 9/3/15 at 6:25 PM, she acknowledged it would be humiliating and undignified for the resident to sit in the dining room and struggle to feed him/herself. 2. Review of the 4/30/15 admission MDS assessment for resident #33 showed the resident required extensive assistance with toileting and locomotion. Review of the care plan dated 9/1/15 showed the resident had frequent bladder incontinence related to decreased mobility and dementia. Further, interventions included "Nursing to provide extensive assist with toilet use as needed." The following concerns were identified:	F 241	and responding timely to resident requests. The Director of Nurses/Designee will conduct random weekly audits for 3 months to confirm that residents are being provided the appropriate and necessary services at meals. The Director of Nurses/Designee will conduct random weekly audits to confirm that residents are being responded to in a timely manner and they are provided the required toileting services. Monitoring: A QA tool will be implemented to monitor dining room assistance during mealtime. DNS/designee will complete QA monitoring tool 3x per week for 30 days. Then random weekly audits for the following 60 days with results taken to monthly QA for identification trends and recommendation for a lesser frequency.	

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F 241	Continued From page 8 a. Observation on 9/2/15 beginning at 1:20 PM showed the resident sitting in a wheelchair located in the dining room. Between 1:20 PM and 1:42 PM the resident called out several times for assistance. The resident initially requested assistance to go to his/her room to "lie down." When the resident received no response, s/he then began calling out that s/he needed to go to the bathroom. At 1:30 PM the resident called, "You're going to have a little puddle...come on, take me to the bathroom!" At 1:35 PM the resident called out again, "I need the bathroom, better hurry!" At 1:42 PM CNA #6 came to take the resident to his/her room, 22 minutes after the resident began asking for assistance. b. Interview with the DON on 9/3/15 at 6:25 PM verified the expectation of the facility staff when a resident calls out for help to go to the bathroom is that staff should promptly assist the resident. The DON also acknowledged the experience would be both undignified and humiliating for the resident.	F 241		
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 review of resident council meeting minutes, and resident and staff interview, the facility failed to act upon the grievances of residents regarding television reception for a period longer than 1 year. Ongoing concerns about television reception and channel availability	F 244	F244 Corrective Action: The television service provider has correcting the signal quality resulting in improved television reception. Identification of Others: The Activity Director/Designee will audit the last 3 months of Resident Council minutes to confirm that concerns voiced during Resident Council have been resolved.	10/18/2015

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F 244	Continued From page 9 were expressed in 9 of 13 months of resident council meeting minutes reviewed. The findings were: Review of the resident council meeting minutes from August 26, 2014 showed the maintenance department manager told the residents the regional facility manager needed to approve any changes such as staying with satellite television, or getting cable television from a local company. The following concerns were identified: a. Review of the resident council meeting minutes from September 23, 2014 showed residents lodged a group concern, stating they did not have clear reception of television channels. b. Review of the resident council meeting minutes from October 28, 2014, November 12, 2014, and December 10, 2014 showed concerns about the television reception remained an ongoing concern. c. Review of the resident council meeting minutes from January 14, 2015 showed concerns about television reception remained an ongoing concern, and "cable company being switched in spring time." d. Review of the resident council meeting minutes from May 26, 2015 showed a resident expressed a concern, asking if the facility was "going to get the local cable channels." e. Review of the resident council meeting minutes from July 28, 2015 showed "local television channels not working" was an ongoing concern. f. Review of the resident council meeting minutes from August 25, 2015 showed "TV channels" was an ongoing concern. g. Group interview with 7 residents on 9/1/15 at 11 AM revealed television reception was a continued concern, with participants complaining about the television reception, and the availability	F 244	System Changes: The Maintenance Director/Designee will confirm the quality of the television reception as a part of monthly maintenance program. The Social Services Director/Designee will audit all concerns voiced at Resident Council for 3 months to confirm the concerns have been satisfactorily resolved. Monitoring: A QA monitoring tool will be implemented and completed by the ED/Designee 3x week for 30 days, then weekly for 60 days and reviewed at monthly QA to identify trends/satisfaction and recommendations for a lesser frequency.	

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F 244	Continued From page 10 of television channels they wanted to watch. h. Confidential interview with a facility resident on 9/2/15 at 9:15 PM revealed, "They've told us for months and months - over a year now - they're gonna fix it, the parts are coming. The TV is important. We're here for the rest of our lives." i. Interview with the maintenance director on 9/3/15 at 4:40 PM revealed the poor reception of local channels was due to problems with the facility's antenna. He was unable to explain the poor satellite channel reception, stating he was unaware of it.	F 244		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This Requirement is not met as evidenced by: Based on medical record review, observation and family and staff interview, the facility failed to ensure there were appropriate and adequate outdoor activities for 2 of 13 sample residents (#47, #75) and 1 non-sample resident (#65) who indicated outdoor activities were important to them. Additionally, the facility failed to provide meaningful activities for 2 of 6 sample residents (#33, #75) with severe cognitive impairment and special needs. The findings were: Related to outdoor activities: 1. Review of the quarterly MDS assessment dated 6/23/15 for resident #75 showed diagnoses that included dementia, anxiety and depression. Review of the resident's functional status showed	F 248	F248 Corrective Action: The activity calendar has been updated to include noted activities that residents would like to participate in, including more outdoor activities and outings. Specific days have been set aside for van usage as to avoid conflict with medical appointments. Resident inventory of likes/dislikes and care plans will be updated. Resident #33 will be reassessed and her care plan updated to provide accommodations for visual impairment. All resident activity care plans will be individualized and clarification will be provided for "sensory stimulation" and "relaxation" activities. Resident #75s care plan has been updated as well. All residents with dementia will have updated care plans to include likes/dislikes and appropriate activities	10/18/2015

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KINDRED TRANSITIONAL CARE AND REHABI	3128 BOXELDER DRIVE CHEYENNE, WY 82001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 11 s/he needed extensive assistance with bed mobility and transfers. Review of the 3/17/15 admission MDS assessment showed activities that were very important included going outside when the weather was good. Review of the "Pleasant and Meaningful Activities" document showed for outdoor time, the resident had enjoyed being outdoors throughout his/her life and continued to enjoy the activity. The following concerns were identified: a. Review of "Group Activity Participation" records from June 2015 through August 2015 showed the resident participated in an activity related to "trips/shopping /being outdoors" on 2 separate occasions in July. The document did not indicate what the activity was. Review of the care plan for resident interests, last revised on 5/28/15, included watching TV, listening to music and reading. Being outdoors was not included. 2. Review of the 8/5/15 admission MDS assessment for resident #47 showed diagnoses that included dementia, Parkinson's disease and muscle weakness. Review of activity preferences showed going outside for fresh air was very important. Review of the resident's functional status showed s/he needed extensive assistance with bed mobility, transfers and locomotion. The following concerns were identified: a. Review of the care plan for interests, last revised on 7/29/15, included watching TV, listening to music and arts and crafts. It did not include taking the resident outside as a preferred activity. Further, it did not indicate the level of assistance the resident required to participate in activities. b. Review of the "Group Activity Participation" record for July and August 2015 did not show the resident was provided any outdoor activities.	F 248	Identification of Others: The Activity Director/Designee will confirm that activity care plans are individualized and clarification is provided for "sensory stimulation" and "relaxation" activities. System Changes: The Activity Director/designee will randomly audit activity care plans for 90 days to confirm that individualized activities are offered and the appropriate sensory activities are provided. Activity consultation will take place to ensure that the Activity Director is including the proper activities on the schedule and those likes/dislikes are reflected in the care plans. In-servicing will be provided about the need for dementia-specific activities, as well as the need to schedule outings, not only do them spontaneously. Monitoring: ED/designee will use QA tool to monitor for care plan updates and activity participation. These will be completed monthly for 3 months and bi-monthly for 6 months thereafter. This will be reviewed at monthly QA meeting.	

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F 248	Continued From page 12 3. Interview with resident #65 on 9/1/15, revealed there were not enough facility outings/outdoor activities. Further, the resident stated s/he had asked for activities to include going to ball games but these were not provided. Review of the 5/23/15 annual MDS assessment for activities showed going outside when the weather was good was very important to the resident. 4. Review of the activities calendars for May 2015 to September 2015 showed 1 outdoor social event scheduled on 7/22/15 at 10 AM. Further review showed there were no additional outdoor activities scheduled during the 5 month period. 5. Interview with the activities director on 9/3/15 at 4:20 PM revealed that there had been some outdoor activities between May 2015 and September 2015. However, there was no documentation for these events. The activities director stated, "We have barbeques, but they're spontaneous and not on the calendar." She reported that outings for residents included activities like going shopping, but these outings were dependent upon the van driver's schedule. She estimated that there had been 3 to 4 outings in July 2015 and one outing in August 2015 but was unable to provide documentation for these events. She also verified that there were no scheduled times for staff to take residents outside for fresh air. Related to residents with severe cognitive impairment and special needs: 1. Review of the 4/30/15 admission MDS assessment for resident #33 showed diagnoses of non-Alzheimer's dementia and macular degeneration of the retina. The following concerns were identified:	F 248		

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F 248	Continued From page 13 a. Observation on 8/31/15 at 5:50 PM showed a sign posted above the resident's bed that read, "[The resident] is blind except for light perception. Review of the "Pleasant and Meaningful Activities" assessment for the resident showed that reading was "not applicable." Review of the resident's care plan, dated 9/1/15, showed interventions that included "Inform of newspaper and daily chronicle availability in activity room" and "provide activity calendar in room." Review of the care plan and activities assessment did not indicate a need to provide accommodations for the resident's visual impairment with regard to these materials. b. Interview with the activities director on 9/3/15 at 3:42 PM revealed that the care plans were not individualized, but the activities assessments for each resident were supposed to be more personalized to each resident's interests. Review of the "Pleasant and Meaningful Activities" assessment for the resident showed "Family Time/Visiting with Friends" was "not applicable" for the resident. However, interview with the resident's family member on 9/2/15 at 2 PM verified family visited the resident daily. c. Review of the resident's "Group Activity Participation" documentation from 5/1/15 to 8/31/15 showed the resident participated in the activity "relaxation" on 6/20/15 and "sensory stimulation" on 7/6/15 but no other activity participation was documented for the resident during this four month time frame. Interview with the activities director on 9/3/15 at 3:42 PM revealed that "sensory groups" were staff visits to the resident's room. The activities director named sensory radio as an activity for a sensory group; however the activities director admitted that she was not familiar with the resident's favorite music. There was no documentation to show what specific activities were provided for the	F 248		

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F 248	Continued From page 14 "relaxation" on 6/20/15 or the "sensory stimulation" on 7/6/15 or how long the activities lasted. 2. Review of the 3/17/15 admission MDS assessment for resident #75 showed diagnoses that included dementia and depression. Activity preferences included listening to music, keeping up with the news, participating in favorite activities and going outside. Review of the "Pleasant and Meaningful Activities" document, used to develop leisure pursuits of interest to the resident based on personal preferences showed the resident enjoyed activities such as church, eating out, listening to music, outdoor time and reading. The following concerns were identified: a. Review of the "Group Activity Participation" record for May 2015 through August 2015 showed there was no documentation of the resident attending activities in May. Further, the resident participated in 1 activity in June, 6 activities in July and 4 activities in August. The activity in June was "sensory stimulation." The documentation did not define what sensory stimulation was provided. Further, it showed the resident wandered in and out of the activity. Review of the July activity record showed the resident went on 2 outings, participated in "cognitive pursuit" twice, cards or other games once, and "relaxation." Review of the response record showed the resident did not actively participate in cognitive pursuit. Further, review of the "Pleasant and Meaningful Activities" document showed playing cards and games was not an activity indicated by the resident as an enjoyable interest. Activities for August included sports/exercise and cognitive pursuit. Review of the meaningful activities document showed exercise/playing sports was not an enjoyable interest for the resident.	F 248		

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F 248	Continued From page 15 b. Review of the care plan for interests, last revised on 5/28/15, showed interventions included informing the resident the newspaper and chronicle was available in the activity room and to assist the resident to activities of choice. Review of the meaningful activities document showed the resident had not indicated s/he enjoyed keeping up with the news/politics. Further, the care plan did not include the activities the resident enjoyed. c. Review of the activities calendar for May through August 2015 showed church services were available every Sunday, communion visits each Monday and Catholic Mass once each month. Review of the meaningful activity document showed the resident had enjoyed church throughout his/her life and continued to do so. Further it showed the resident was Catholic. In addition, the resident indicated watching movies/TV and attending parties were enjoyable activities. Review of the activity calendars showed there was a weekly Saturday matinee. Review of the "Group Activity Participation" records failed to indicate the resident attended or was offered the opportunity to attend. 3. Interview with the activities director on 9/3/15 at 4 PM revealed activities were sometimes provided by the floor nursing staff. Activities for residents with dementia who did not reside on the secure unit were based on a list of activities provided to the CNAs. Further, she acknowledged care plans were not specific to each residents' individual interests. The director indicated the activities department did not have enough staff to provide the appropriate activities for residents with dementia.	F 248		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253	F253 Corrective Action: All unclean and damaged items noted will be appropriately cleaned and repaired. Multiple areas of floor have been stripped and waxed and floor tiles will be replaced as needed. Damaged kick plates, doors, vents, wall coverings have also been repaired/replaced, as to allow for a surface that is able to be sanitized. Corrective Action: Room 215: The black discoloration on the tiles will be cleaned or the tiles will replaced. The transition strip will have the debris removed. And, the kick plate on the bathroom door will be repaired and/or replaced. Room 217: The black discoloration on the tiles will be cleaned or the tiles will be replaced. Room 219: The black discoloration on the tiles will be cleaned or the tiles replaced. The closet moulding will be cleaned	10/18/2015

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F 253	Continued From page 16 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, review of the facility grievance log, and staff interview the facility failed to provide a safe, clean, comfortable, and homelike environment for 3 of 3 facility floors (1st, 2nd, 3rd). The findings were: 1. Observation of room 215 on 9/1/15 at 10:41 AM showed the floor in the room had black discoloration on the tiles throughout the room. There was visible build of of dirt and debris on both sides of the transition strip at the room entrance. Further observation showed the kickplate on the bathroom door was damaged, exposing underlying wood that created an unsanitizable surface. 2. Observation of room 217 on 9/1/15 at 10:43 AM showed the floor had black discoloration on the tiles throughout the room. 3. Observation of room 219 on 9/1/15 at 10:45 AM showed the floor had black discoloration on tiles throughout the room. The base of the closet moulding was discolored and had a build up of dirt and debris surrounding it. 4. Observation of room 221 on 9/1/15 at 10:47 AM showed build up of dirt and debris around the transition strip of the entry door. 5. Observation of room 218 on 9/1/15 at 10:48 AM showed the floor had black discoloration on the tiles throughout the room. Further observation showed the bathroom floor had 2 large areas of	F 253	Room 221: The transition strip area will be cleaned. Room 218: The black discoloration on the tiles will be cleaned or the tiles will be replaced. The bathroom discoloration on the floor will be removed, cleaned, or the floor replaced. The vent cover will be repaired. And the tiles located on the outside of the bathroom will be repaired or replaced. Room 202: The black discoloration on the tiles will be cleaned or the tiles will be replaced. Room 211: The black discoloration on the tiles will be cleaned or the tiles will be replaced. The discoloration on the bathroom floor will be removed, cleaned, or floor replaced. The bathroom vent will be repaired and secured to the unit. The bathroom door frame will be repaired. Room 227: The kickplate will be repaired or replaced. Room 206: The discoloration on the bathroom floor will be removed, cleaned, or the floor replaced. The	

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F 253	Continued From page 17 yellow discoloration that measured 24" (inches) by 12" (inches) near the toilet. Additionally, the vent cover was damaged and there were 2 tiles located outside the bathroom that measured 12" by 12" and were broken, cracked, or chipped and created an unsanitizable surface. 6. Observation of room 202 on 9/1/15 at 10:57 AM showed the floor had black discoloration on the tiles throughout the room. 7. Observation of room 211 on 9/1/15 at 10:59 AM showed the floor had black discoloration on the tiles throughout the room. Continued observation showed the bathroom floor had yellow discoloration that measured 36" by 12" near the toilet. Further observation of the bathroom showed a vent cover that was damaged and not fully secured to the unit. The door frame to the bathroom was damaged and exposed underlying metal where rust had developed, creating an unsanitizable surface. 8. Observation of room 227 on 9/1/15 at 11:24 AM showed the kickplate was damaged and exposed the underlying wood creating an unsanitizable surface. 9. Observation of room 206 on 9/1/15 at 11:28 AM showed the bathroom floor had yellow discoloration that measured 24" by 24" near the toilet. The floor was sticky. Further observation showed the ceiling vent was missing the exhaust cover. 10. Observation of room 318 on 9/3/15 at 10:41 AM showed the floor had black discoloration noted on tiles throughout the room. 11. Observation of room 315 on 9/3/15 at 10:46	F 253	floor will be cleaned. The ceiling vent will have an exhaust cover provided. Room 318: The black discoloration on the tiles will be cleaned or the tiles will be replaced. Room 315: The closet door will be placed on the rail and secured. North End of 2nd Floor B Hall: The black marks on the kickplates on the clean utility room, supply room, soiled utility room, and the unit manager office will be removed or the kickplate will be replaced. 2nd Floor Dining Area: The black discoloration on the tiles will be cleaned or the tiles will be replaced. The dining room edges will be cleaned. Common Area – West Elevator – East Elevator– 2nd Floor: The tiles identified will be repaired or replaced. Dining Room Behind Nurse's Station – 3rd Floor: The tiles identified will be repaired or replaced. Activities Room: The vent cover will be repaired or replaced and secured to the vent	

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F 253	Continued From page 18 AM showed the closet door was not on the rail or secured and was leaning against the shelf in the closet. 12. Observation of the hallway outside room 219 at 10:45 AM showed the floor had black discoloration on the tiles near the entry door of the room. Further observation showed 2 floor tiles that measured 12" by 12" that were broken, cracked, or chipped and created an unsanitizable surface. 13. Observation of the north end of 2nd floor B hall on 9/1/15 at 10:50 AM showed there were black marks to the kickplates on the doors of the clean utility room, supply room, soiled utility room, and unit manager office that measured 30" up from the floor and spanned the width of the doors. 14. Observation of the 2nd floor dining area on 9/1/15 at 10:58 AM showed, after cleaning was performed, black discoloration remained to the tiles throughout the dining area and dirt and debris was noted around the edges of the room between the floor and wall. 15. Observation of the common area by the west elevator on the 2nd floor on 9/1/15 at 11:05 showed there were 8 tiles measuring 12" by 12" that were broken, cracked, or chipped and created an unsanitizable surface. Observation of the common area of the east elevator on second floor at that time showed there were 6 tiles measuring 12" by 12" that were broken, cracked, or chipped and created an unsanitizable surface. 16. Observation of the dining room behind the 3rd floor nurses' station on 9/3/15 at 10:35 AM showed there were 9 tiles that measured 12" by	F 253	3rd Floor – A Hall – Near the Fire Exit: The metal bracket for the vent cover will be repaired or replaced. Reflections Unit: The black discoloration on the tiles near rooms 329, 328, 327, 324, and 325 will be cleaned or the tiles will be replaced. Wall base will be installed on walls with missing wall base. Reflections Unit Dining Room: The wall under the sink will be cleaned. 2nd Floor Nurse's Station: The area behind the computer printer will be cleaned. The wood at the base of the station will be repaired or replaced. 2nd Floor Nurse's Station: The south end section with yellow and black substance will be repaired, cleaned, or replaced. 3rd Floor Nurse's Station: The wood base with discoloration will be repaired, cleaned, or replaced. The damaged Formica will be repaired or replaced. West Shower Room: The wall with dried substance will be cleaned, repaired, or replaced.	

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F 253	Continued From page 19 8" that were cracked, chipped or broken creating an unsanitizable surface. Further observation showed 9 tiles measuring 12" by 12" that were broken, cracked, or chipped and created an unsanitizable surface. 17. Observation of the activities room on 1st floor on 9/1/15 at 12:18 PM showed there was a damaged vent cover that was not fully secured to the vent. 18. Observation of the 3rd floor A hall, near the fire exit, on 9/3/15 at 10:32 AM showed the metal bracket for the vent cover was damaged and it was sticking out 1 1/2" at the bottom where it contacted the floor. 19. Observation of the hallway in the Reflections Unit on 9/3/15 at 11:02 AM showed black discoloration around the edges of wall and floors outside rooms 329, 328, 327, 324, and 325. Further observation showed the wall base was missing on 5 of 6 walls which exposed the underlying drywall and metal and created an unsanitizable surface. 20. Observation of the Reflections dining area on 9/3/15 at 11:06 showed the wall under the sink was stained with dried food particles. 21. Observation of the 2nd floor nurse's station on 9/1/15 at 11:05 AM showed food wrappers and dirt and food build-up on the surface behind the computer printer. Continued observation showed the base of the station had exposed wood that was damaged and created an unsanitizable surface. 22. Observation of the 2nd floor nurse's station on 9/2/15 at 12 PM showed a cabinet on the	F 253	East Shower Room – 2nd Floor: The black discoloration area around the base of the shower stall will be cleaned, repaired, or replaced. The tiles with brown discoloration below the shower head will be cleaned, repaired, or replaced. The chair in the shower room will be removed and replaced. West Shower Room – 3rd Floor: The brown stains on the base of the toilet will be cleaned or the toilet will be replaced. The chair in the shower room will be removed and replaced. East Shower Room – 3rd Floor: The black discoloration area around the base of the shower stall will be cleaned, repaired, or replaced. The stained walls will cleaned or replaced. The area near the drain will have the discoloration removed. 2nd Floor Public Bathroom: The black discoloration on the tiles will be cleaned or the tiles will be replaced. The edges on the floor and walls will be cleaned. Public Bathroom – First Floor: The black discoloration on the tiles will be cleaned or the tiles will be replaced.	

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F 253	Continued From page 20 south end of the station had a dried yellow and black substance around the leg of the cabinet. 23. Observation of the 3rd floor nurses' station on 9/3/15 at 10:26 AM showed the wood base of the station had built-up dirt and debris and black discoloration on the wood. Further observation showed the south corner of the nurses' station had damage to the Formica that measured 3 1/2" by 2 1/2" and exposed the underlying wood creating an unsanitizable surface. The north west corner of the nurses' station had 3 areas of damaged Formica. The top area measured 1" by 1 1/2" and exposed the underlying wood creating an unsanitizable surface. The middle area measured 1" by 1" and exposed the underlying wood creating an unsanitizable surface. The lower area measured 1" by 1" and exposed the underlying wood creating an unsanitizable surface. 24. Observation of the west shower room on the 2nd floor on 9/3/15 at 10:16 AM showed there was a dried substance on the wall near the toilet that was yellow and brown in color. 25. Observation of the east shower room on the 2nd floor on 9/3/15 at 10:19 AM showed there was black discoloration around the base of the shower stall where the floor met the walls. Further observation showed there was brown discoloration on the tiles below the shower head unit and used wet washcloths on the floor. Continued observation showed there was a wooden chair with an upholstered seat that had brown streaks in the center of the chair, and dirt and debris was built up around the edges the room. 26. Observation of the west shower room on 3rd	F 253	Identification of Others: The Maintenance Director/Designee and the Housekeeping Supervisor/Designee will conduct a facility-wide audit to determine if any of the areas cited in F-253 are present in other areas of the Center. System Changes: The Directors of Housekeeping and Maintenance will be in-serviced as to the importance of having a clean and sanitary environment. A new Director of Housekeeping has been appointed. Updated cleaning schedules have been created. The Maintenance Director/Designee and the Housekeeping/Designee will incorporate into their respective preventative maintenance and housekeeping cleaning programs routine audits to confirm compliance with maintaining the Center is an appropriate homelike environment. Monitoring	

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F 253	Continued From page 21 floor on 9/3/15 at 10:53 AM showed brown stains at the base of the toilet. Further observation showed a wooden chair that had stains on the upholstered seat. 27. Observation of the east shower room on 3rd floor on 9/3/15 at 10:57 AM showed black discoloration around the base of the shower stall where the floor met the walls. Further observation showed there were brown stains on 2 of 3 walls in the shower stall and discoloration that was black and brown surrounding the drain. 28. Observation of the 2nd floor public bathroom on 9/2/15 at 12:35 PM showed the floor had black discoloration, and dirt and debris was built up around the edges of the floor and walls. 29. Observation of the public bathroom on the first floor on 9/3/15 at 10:13 AM showed the floor had black discoloration. 30. Review of the facility complaint log from February 2015 to August 2015 showed 24 complaints were filed about facility sanitation. Further review showed 6 resolution comments by the facility that indicated "short staffing" in the housekeeping department. 31. Interview with the housekeeping manager on 9/3/15 at 4:40 PM revealed the facility did not have enough staff to maintain cleanliness and he was not surprised by the findings. The housekeeping manager confirmed the environment was not clean and did not create a homelike environment for the residents. 32. Interview with the maintenance director on 9/3/15 at 4:40 PM revealed the identified areas were a safety risk and created an unsanitary	F 253	The ED/Designee will do weekly walking rounds with the director of housekeeping to validate there is a clean and sanitary environment. ED/designee will use QA tool to monitor for unclean or damaged areas weekly x 3 months. This will be reviewed at monthly QA meeting for further evaluation and educational opportunities.	

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F 253	Continued From page 22 environment.	F 253		
F 312 SS=D	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, medical record review and staff, resident and family interview, the facility failed to provide necessary dining assistance during 2 observed meals for non-sample resident #31. The findings were: 1. Review of the 8/27/15 admission MDS assessment showed resident #31 required the physical assistance of one person. Additionally, the care plan, initiated on 8/27/15, showed the resident required staff participation to eat. The following concerns were identified: a. Observation of the meal on 9/2/15 beginning at 12:57 PM showed resident #31 was served a meal that included a piece of meat that was not cut into small pieces or mechanically ground. The resident's hands were shaky when s/he attempted to cut the meat. The resident's hand was also shaky when s/he attempted to reach for and drink coffee, and take bites of food. By the end of the meal the resident had eaten 50% of the meat but left the bread roll and fries on the plate and did not drink any milk. At no point during the meal did a CNA or other staff member assist or offer to assist the resident with eating. b. Observation of the meal on 9/3/15 beginning at 12:10 PM showed the resident was	F 312	F312 Corrective Action: Resident #31 continues on PT/OT/ST and has had her diet and adaptive equipment assessed. Identification of Others: The Director of Nurses/Designee will conduct a facility-wide audit to confirm that residents are being provided the appropriate and necessary services at meals. System Changes: SDC will re-educate nursing staff on ADL care for dependent residents, required assistance for ADLs, for dependent residents will be incorporated into the assignments of CNAs. The Director of Nurses/Designee will conduct random weekly audits for 3 months to confirm that residents are being provided the appropriate and necessary services at meals.	10/18/2015

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F 312	Continued From page 23 sitting in the dining room. At 12:30 PM, the meal was brought out, at which time the resident attempted to feed him/herself unsuccessfully. The resident was observed to have difficulty picking up french fries and keeping food on utensils. At 12:45 PM, the resident had managed to eat a small portion of fish and two wedge-cut french fries. S/he had been unable to drink any milk or eat any of the corn bread or lemon pie. The resident received no assistance from staff, leaving the dining room at 12:59 PM after consuming approximately 25% of the meal. Review of the progress note dated 9/3/15, timed 3:13 PM, showed the resident "ate in the dining room with assistance from staff " although observation showed no assistance was provided. c. Interview with a family member on 9/3/15 at 12:40 PM revealed, "They just need to help, [s/he] can't feed [her/himself]; it just falls off and [s/he] can't get any." d. Review of a progress note dated 8/18/15, timed 9:10 PM, showed the resident had trouble eating meals without assistance due to hand tremors that caused food to fall off utensils. e. Review of a progress note dated 8/20/15, timed 4:51 PM, showed the registered dietitian wrote an order to downgrade the resident's diet to a mechanical soft, finger food diet, due to the resident's inability to eat with utensils. f. Review of a dietitian's progress note dated 8/24/15, timed 12 PM, showed less than 25% of meals were being consumed due to the resident's shaking. g. Review of a progress note dated 9/2/15, timed 6:08 PM, showed the resident continued to struggle with self-feeding and stated the resident needed "assistance during meal-time." h. Interview with the resident on 8/31/15 at 9:32 AM, revealed the resident had an inability to hold a spoon and did not have teeth to chew food.	F 312	Monitoring: A QA tool will be implemented to monitor ADL assistance. DNS/Designee will complete this tool 3x week x 30 and 1x weekly for 60 days with results taken to QA for identification of trends and recommendation for lesser frequency.	

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F 312	Continued From page 24 The resident stated "I am hungry, but I just can't eat by myself because I shake too much and I don't have any teeth." i. Interview with the director of nursing on 9/3/15 at 6:50 PM verified the resident was weak, had no teeth, should have received a mechanical soft meal, and should have been assisted with eating.	F 312	F318 Corrective Action:	10/18/2015
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This Requirement is not met as evidenced by: Based on medical record review and staff interview, the facility failed to have an active program of restorative nursing care for 4 of 4 sample residents (#17, #47, #55, #77) with identified range of motion limitations. The findings were: Review of the 6/15/15 annual MDS assessment for resident #17 showed the resident had functional limitation in range of motion with both lower extremities. Review of the medical record showed no evidence the resident was receiving restorative nursing services designed to increase range of motion or prevent further decrease. Review of the 8/5/15 admission MDS assessment for resident #47 showed the resident had functional limitation in range of motion of one lower extremity. Review of the medical record	F 318	Resident #17, 47, 55, and 77 have received therapy evaluations. Identification of Others: The Director of Nursing/Designee will conduct a facility-wide audit to confirm that residents requiring restorative nursing services are provided those services. System Changes: SDC will provide education to CNAs to provide ROM, walk to dine, or appropriate programs during their assignments The Director of Nursing/Designee will conduct routine weekly audits for 90 days to confirm that residents requiring restorative nursing services are provided those services.	

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F 318	Continued From page 25 showed no evidence the resident was receiving restorative nursing services designed to increase range of motion or prevent further decrease. Review of the 8/26/15 quarterly MDS assessment for resident #55 showed the resident had functional limitation in range of motion of one lower extremity. Review of the medical record showed no evidence the resident was receiving restorative nursing services designed to increase range of motion or prevent further decrease. Review of the 7/10/15 quarterly MDS assessment for resident #77 showed the resident had functional limitation in range of motion with both upper extremities. Review of the medical record showed no evidence the resident was receiving restorative nursing services designed to increase range of motion or prevent further decrease. Interview with rehabilitation technician #1 on 9/3/15 at 2:15 PM revealed the facility did not have a restorative nursing program. She was unable to say exactly when the restorative program had ceased, but said it had "been months" since there had been a restorative program in the facility. Interview with the DON on 9/3/15 at 6:25 PM revealed the facility did not have a restorative program due to inadequate staffing levels. She further acknowledged residents would benefit from having a restorative program, and instead the facility was referring residents for skilled therapy whenever they showed a decline.	F 318	Monitoring: A QA tool will be implemented and completed 3x week x 30 and 1x weekly for 60 days thereafter by the DNS/ Designee with results taken to the monthly QA meeting for identification of trends and recommendation for lesser frequency.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		

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F 323	Continued From page 26 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: Based on medical record review, observation, and resident and staff interviews, the facility failed to ensure 2 of 5 sample residents (#47, #49) observed during transfers were evaluated for safety and appropriateness of lift use. The findings were: 1. Review of the 8/5/15 admission MDS assessment for resident #47 showed diagnoses that included dementia, Parkinson's disease and muscle weakness. Review of the resident's functional status showed s/he needed extensive assistance with bed mobility, transfers and locomotion. Review of the Physical Therapy Plan of Care dated 7/27/15 showed "Right ankle range of motion severely limited due to previous injury." Further, it showed the resident was referred for therapy due to a right inverted ankle, which prevented the resident from full weight bearing and the resident used a wheelchair as the primary means of mobility. The following concerns were identified: a. Observation on 8/31/15 at 10:45 AM showed CNA #1 and CNA #2 provided incontinence care for the resident. The CNAs prepared to transfer the resident from the bed to the wheelchair. CNA #1 was uncertain how the resident was to be transferred and left the room, returning with a full body lift and the CNAs then transferred the resident. b. Observation on 9/2/15 at 2:30 PM showed CNA #3 took the resident to the bathroom. The	F 323	F323 Corrective Action: Residents #47 and #49 will have their transfer status clarified and re-evaluated by therapy. The updated status will be care plan and communicated to the nursing staff. All other residents will be reviewed to ensure that a proper transfer status is known. Identification of Others: The Staff Development Coordinator/Designee will conduct a facility-wide audit to confirm that nursing staff are using the appropriate lift correctly. The MDS coordinator/designee will conduct a facility wide audit to confirm that care plans are updated to reflect the current transfer status for each resident. System Changes: MDS coordinator will be in-serviced to confirm that all residents have an updated, current and accurate transfer status.	10/18/2015

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F 323	Continued From page 27 CNA assisted the resident from a sitting to standing position with a gait belt. The resident stood and held onto the grab bar mounted on the wall in the bathroom while the CNA changed the resident's incontinence pad. The resident was only able to stand for approximately 30 seconds before needing to sit down after his/her knees started buckling. c. Review of the care plan for ADL care, last revised on 8/5/15, only showed the resident needed extensive assistance with bed mobility and transfers. It did not show how the resident was to be transferred or any devices that were to be used. Further review of the entire care plan failed to show how the resident was to be safely transferred. d. Review of the physical therapy notes dated 7/27/15 through 8/31/15 and progress notes dated 7/23/15 through 8/30/15 failed to show any evaluation had been completed for safe and appropriate transfers. 2. Review of the 7/21/15 quarterly MDS assessment for resident #49 showed diagnoses included muscle weakness and osteoarthritis. Further it showed the resident needed extensive assistance with bed mobility, transfers, locomotion and toileting. The following concerns were identified: a. Observation on 9/1/15 at 11:40 AM showed CNA #1 and CNA #2 transferred the resident from the bed to the wheelchair with a sit-to-stand lift and took the resident to the toilet. The resident appeared to be using the straps of the lift extensively for support and supporting little of his/her own weight. The resident was then assisted with the use of a gait belt to a standing position and pivoted to the toilet from the wheelchair. An interview with the resident on 9/3/15 at 11:15 AM indicated the sit-to-stand lift	F 323	The MDS Coordinator/Designee will conduct random weekly audits for 90 days to confirm that care plans are updated to reflect the current transfer status for each resident. Monitoring: A QA tool will be used for 90 days by DON/designee to ensure updates have been completed and interviews with staff will be conducted to ensure they are familiar with resident transfer status. This will be reviewed at monthly QA meeting.	

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F 323	Continued From page 28 was uncomfortable when used during transfers. b. Review of the care plan for bladder incontinence, last revised on 7/21/15, showed the resident needed extensive assistance with toilet use. It did not show how the resident was to be transferred. Further review of the entire care plan did not indicate how the resident was to be transferred. It only showed "Nursing to provide extensive assist with bed mobility and toilet use as needed." c. Review of the progress note dated 7/17/15 showed the resident periodically complained of right shoulder pain due to a prior dislocation. Further, the note stated the resident "...is really having a hard to [time] using the lift to transport to go to the bathroom." Further, it showed the nurse practitioner discussed the use of Hoyer lift for transfers with the resident. Review of the nurses' notes dated 7/10/15 through 9/1/15 and physical therapy notes dated 7/10/15 through 8/19/15 failed to show any evaluation had been completed for safe lift transfers. 3. During an interview with the DON on 9/3/15 at 6:25 PM, she acknowledged the residents needed to be evaluated for the use of appropriate lifts to ensure their safe transfers.	F 323	F353 Corrective Action: The facility will develop and implement strategies addressing the recruitment and retention of staff. Call lights are being answered in a timely manner and residents needs are being met according to their plan of care. Identification of Others: The facility will conduct random weekly call light audits to confirm an adequate response time to the call light. Audit/interviews of call lights were completed and no other concerns were noted.	10/18/2015
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing	F 353		

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F 353	Continued From page 29 care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This Requirement is not met as evidenced by: Based on observation, review of resident council meeting minutes, and staff and resident interview, the facility failed to ensure 2 of 3 nursing units were sufficiently staffed to ensure nursing services were provided according to resident needs. The findings were: 1. Group meeting with 7 residents on 9/1/15 at 11 AM revealed facility call lights were not answered in a timely manner, that it could take up to an hour for call lights to be answered, and there was no particular shift that was worse; call lights were not answered in a timely manner on all shifts. All of the residents present at the group meeting resided on the second or third floor nursing units. 2. Review of resident council meeting minutes from 8/25/15 revealed resident concerns that call lights were not being answered in a timely manner, and this was an ongoing concern. 3. Observation on 9/2/15 at 8:45 PM showed there were 7 call lights active on the 3rd floor. LPN #1 was observed to be working at the medication cart, but no CNAs were visible and the call lights remained active. At 9:05 PM, the	F 353	System Changes: Facility staff have been reeducated on call light response times and following residents plan of care. Monitoring: Random weekly audits of call light response times to validate residents individual needs are addressed x 3 months. Audits will be reviewed at the QAPI meeting for 3 months.	

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F 353	Continued From page 30 facility DON, the secure unit manager, and the staff development coordinator arrived on the floor and began answering call lights. Interview with CNA #8 at 9:08 PM, and CNA #3 at 9:10 PM revealed facility managers were not typically at the facility at night to answer call lights and provide resident care. 4. Interview with rehabilitation technician #1 on 9/3/15 at 2:15 PM revealed the facility did not have a restorative nursing program. She was unable to say exactly when the restorative program had ceased, but said it had "been months" since there had been a restorative program in the facility. 5. Interview with the DON on 9/3/15 at 6:25 PM revealed the facility did not have a restorative program due to inadequate staffing levels. She further acknowledged residents would benefit from having a restorative program, and instead the facility was referring residents for therapy whenever they showed a decline.	F 353		
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This Requirement is not met as evidenced by: Based on observation, review of the grievance log, policy and procedure review, and staff interview, the facility failed to ensure foods were maintained at a temperature considered palatable for 1 of 1 meals tested. The findings were:	F 364	F364 Corrective Action: All food temps will be monitored before the meal to ensure the food is being served at the proper temperature. Identification of Others: The Dietary Manager/Designee will conduct temperature audits daily for each meal to confirm the contents of the meal are served at the appropriate temperature. System Changes: Dietary Manager and Registered Dietician in-service dietary staff about achieving and maintain proper food temperatures as well as how to record them. The Dietary Manager/Designee will conduct temperature audits daily for each meal to confirm the contents of	10/18/2015

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F 364	Continued From page 31 1. Review of the resident grievance log showed residents complained about food not being served hot in February, March, April, June, July, and August 2015. 2. Group interview with 7 residents on 9/1/15 at 11 AM revealed facility meals were consistently cold. 3. Observation of a test tray provided on 9/2/15 at 6:40 PM showed the temperature of the chicken breast was 118 degrees Fahrenheit, the temperature of the scalloped corn was 90 degrees Fahrenheit, and the temperature of the baked potato was 120 degrees Fahrenheit. 4. Review of the facility policy titled "Food Preparation" released 5/28/15 showed "...Food temperatures are kept at the appropriate levels to maintain flavor and palatability..." 5. Interview with the Dietary Manager on 9/2/15 at 6:50 PM confirmed the meal temperatures were "cold" and the chicken breast was "lukewarm" to touch.	F 364	the meal are served at the appropriate temperature. Monitoring: A QA tool will be used by Dietary Manager and Registered Dietician to confirm that the food is being served at the proper temperature. This will be reviewed monthly with findings to be brought QA meeting for further evaluation and educational opportunities.	
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This Requirement is not met as evidenced by: Based on observation, medical record review and staff interview the facility failed to provide necessary assistive devices for 1 randomly observed non-sample resident (resident #31). The findings were:	F 369	F369 Corrective Action: Resident #31 continues on PT/OT/ST and has had her diet and adaptive equipment assessed.	10/18/2015

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F 369	Continued From page 32 1. Review of the admission care plan dated 8/27/15 showed resident #31 needed to be assessed for necessary adaptive equipment. 2. Review of the progress note dated 8/24/15, timed 12 PM, showed the resident's diet was downgraded to a mechanical soft, finger food diet due to shaking, and a speech consult was requested to assess for adaptive equipment. 3. Review of the progress note dated 8/28/15, timed 12:35 PM, showed "...Resident has some weighted utensils and finger foods, double handled cup with straw..." 4. Review of the progress note dated 9/2/15, timed 4:02 PM, showed the resident was reviewed by the weekly interdisciplinary team and had "...good appetite, but difficulty self-feeding; downgraded to mech [mechanical] soft finger foods d/t [due to] shaking; res [resident] now using 2-handle cup with straw, weighted utensils, divided plate..." 5. Observation of the meal on 9/2/15 beginning at 12:57 showed the resident was not given a divided plate, two-handled cup, or a mechanical soft meal to facilitate eating. The resident was served a piece of meat that was not cut, French fries, a dinner roll, and a cup of milk After being unable to cut the meat due to hand tremors and weakness, approximately half of the meat was eaten. The resident was unable to eat the roll or drink the milk. 6. Observation of the meal on 9/3/15 beginning at 12:10 showed the resident was not given a divided plate, two-handled cup, or a mechanical soft meal to facilitate eating. The resident was served a piece of fish that was not cut, French	F 369	Identification of Others: The Director of Nursing/Designee will conduct a facility-wide audit to confirm that residents requiring the use of adaptive equipment are being provided the adaptive equipment. System Changes: SDC will reeducate nursing staff on ADL care for dependent residents, required assistance for ADLs, for dependent residents will be incorporated into the assignments of CNAs. The Director of Nursing/Designee will conduct random weekly audits for 90 days to confirm that residents requiring the use of adaptive equipment are being provided the adaptive equipment. Monitoring: A QA tool will be implemented to monitor ADL assistance. DNS/Designee will complete this tool 3x week x 30 days and weekly for 60 days thereafter with results taken to QA for identification of trends and recommendation for lesser frequency.	

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F 369	Continued From page 33 fries, cornbread, lemon pie, and a cup of milk. After being unable to cut the fish due to hand tremors and weakness, approximately half of the fish and French fries were eaten. The resident was unable to eat the cornbread or the lemon pie. Over half of the cup of milk remained on the table. 7. Interview with the DON on 9/3/15 at 6:50 PM confirmed the resident should have been provided a divided plate and double-handled cup.	F 369	F371 Corrective Action: The oven top was cleaned and the walk-in cooler and other food storage areas were checked for outdated food.	10/18/2015
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 items did not remain in use after the expiration date in 1 of 3 observed storage areas (walk-in cooler) of the kitchen. Further, the facility failed to ensure machinery was clean and sanitary in 1 of 1 facility kitchen. The findings were: 1. Observation on 8/31/15 at 9:35 AM showed a container of ham was placed into the walk-in cooler with a "use by date" of 8/30/15. The ham was used for the lunch meal served on 8/31/15. 2. Observation of the "Vulcan" oven on 9/2/15 at	F 371	Identification of Others: The Dietary Manager/Designee will conduct a facility-wide audit to confirm that no food products are present with an expired use-by date. The Dietary Manager/Designee will conduct a facility-wide audit to confirm that equipment used for the preparation or heating of food are clean. System Changes: Dietary Manager and Registered Dietician will in-service dietary staff about proper date labeling methods. A new cleaning schedule will be developed. The Dietary Manager/Designee will conduct random weekly audits for 90 days to confirm that no food products	

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F 371	Continued From page 34 4:16 PM showed there were dirty metal racks stored on top of the oven. Further observation showed the top of the oven was covered with visible crumbs, dust, grease, and grime. 3. Review of the facility policy titled "Food and Supply Storage" with a release date of 8/31/12 showed "All food, non-food items and supplies used in food preparation shall be stored in such a manner as to maintain safety and sanitation of the food or supply for human consumption as set forth in the Federal Drug Administration Food Code, state regulations, and city/county health codes...Use by: date is the last date recommended for the use of product while at peak quality..." 3. Interview with the Dietary Manager on 9/2/15 at 3:50 PM revealed that any items that were past the use by date should be thrown out. 4. Interview with the Dietary Manager on 9/2/15 at 4:20 PM revealed the tops of the ovens should have been cleaned on 8/1/15, had been signed off as being completed, and were not cleaned when they should have been.	F 371	are present with an expired use-by date. The Dietary Manager/Designee will conduct random weekly audits for 90 days to confirm that equipment used for the preparation or heating of food are clean. Monitoring: A QA tool will be used by Dietary Manager and Registered Dietician to ensure that the food is being properly labeled when stored. It will also be used to ensure the cleaning schedule is being followed, by inspecting the items that are documented as being cleaned. These will be performed monthly for 3 months, then bi-monthly for 6 months thereafter. This will be reviewed at monthly QA meeting.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and	F 425	F425 Corrective Action: Medication carts and medication rooms were audited for expired and undated medications.	10/18/2015

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F 425	Continued From page 35 administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This Requirement is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure expired medications were not available for use in 2 of 2 medication storage rooms, and failed to properly label medication in 1 of 3 medication carts inspected within the facility. The findings were: 1. Observation of 2 medication storage rooms on 9/3/15 beginning at 10:25 AM identified the following expired medications: Rugby brand calcium chews 500 mg with an expiration date of 6/15, Equaline brand children's allergy syrup with an expiration date of 5/15, Nicotine transdermal patch with an expiration date of 5/15, Enulose lactulose 10g/15ml with an expiration date of 2/15, loratadine 10 mg with an expiration date of 7/15, zinc sulfate tablets 220 mg with an expiration date of 7/15, and NyQuil Cold & Flu Night-time, labeled with a resident's name, that had an expiration date of 6/15. 2. Observation of a 3rd floor medication cart on 9/3/15 at 10:45 AM showed a Novolog Flex Pen being used for resident insulin administration that was not labeled with an 'in-use' date. 3. Interview with the DON on 9/3/15 at 7:30 PM revealed the facility's expectation that all staff	F 425	Identification of Others: The Director of Nursing/Designee will conduct a facility-wide audit to confirm no expired or undated medications are present in medication rooms or medication carts. System Changes: Education has been provided to licensed staff regarding proper storage and use of medications. The Director of Nursing/Designee will conduct random weekly audits 90 days to confirm no expired or undated medications are present in the medication carts or medication rooms. Monitoring: A QA tool will be implemented and completed by the DNS/Designee random weekly audits for 90 days with results reviewed at the monthly QA to identify trends and recommendation for a lesser frequency.	

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F 425	Continued From page 36 were responsible for checking for expired medications and that insulin pens are to be dated when opened.	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F441 Corrective Action: Staff are placing resident #17s urine collection bag below the level of the bladder during cares. Identification of Others: The DON/designee will conduct a facility-wide audit will be conducted on all residents using an indwelling catheter to confirm the staff are placing the urine collection bag below the level of the bladder during cares. System Changes: The Staff Development Coordinator and/or Designee will conduct an in-service with nursing staff regarding the appropriate placement of the urine collection bag while cares are being provided. The Staff Development Coordinator and/or Designee will conduct random weekly audits/observations for 3 weeks of staff providing care to	10/18/2015

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F 441	Continued From page 37 This Requirement is not met as evidenced by: Based on observation, staff interview, and policy and procedure review the facility failed to ensure infection prevention practices were followed by staff for 1 of 3 sample residents (#17) with an indwelling urinary catheter. The findings were: 1. Review of the 6/6/15 quarterly MDS assessment showed resident #17 had diagnoses that included CVA (cerebrovascular accident) and urinary urethral stricture. Further review showed the resident required the extensive assistance of 2 or more persons for transferring and bed mobility, and the extensive assistance of 1 person for dressing and personal hygiene. Further review showed the resident had an indwelling urinary catheter and a history of urinary tract infection. The following concerns were identified: a. Observation on 9/1/15 at 6:15 PM showed CNA #1 and CNA #7 assisted the resident to get ready for bed and transfer. CNA #1 emptied the urine collection bag and then secured it to the bottom of the sit-to-stand lift for transfer. The resident was lifted from the wheelchair and lowered onto the side of the bed. The CNAs then assisted the resident to lay in the bed, however the urine collection bag tubing was under the resident's leg. CNA #1 attempted to reposition the urine collection bag by tucking it under the resident's leg; however, the CNA lifted the urine collection bag to her chest level, above the resident's bladder. Visible urine in the collection tubing flowed backwards toward the resident's bladder. b. Interview with the staff development coordinator on 9/3/15 at 3:10 PM revealed the urine collection bag should have been kept below	F 441	residents with an indwelling catheter to confirm the appropriate location of the urine collection bag. Monitoring: A QA tool will be used by DON/designee to ensure that residents with catheters are being handled properly. Audits to be completed 3 x week x 1 month then bi weekly x 2 months. This will be reviewed at monthly QA meeting for further evaluation and educational opportunities.	

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F 441	Continued From page 38 the bladder to prevent backflow of urine into the bladder as it can cause an infection. c. According to the facility policy titled "Indwelling Urinary Catheter Care" revised 8/13/12 showed "...16. Position the collecting-bag below the level of the bladder at all times..."	F 441	F465	10/18/2015
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This Requirement is not met as evidenced by: Based on observation and staff interview the facility failed to provide a safe environment for residents, staff, and visitors in 1 of 1 parking lots, 1 of 5 shower rooms (2nd Floor East), and 1 of 1 ice machine storage rooms. The findings were: 1. Observation on 9/3/15 at 6 PM showed a pot hole in the parking lot that measured 24" (inches) by 38" and was 4" (inches) deep creating an unsafe environment. 2. Observation on 9/3/15 at 6:02 PM showed a pot hole in the parking lot that measured 10" by 20" and was 2 1/2" deep creating an unsafe environment. 3. Observation on 9/3/15 at 6:03 PM showed a pot hole in the parking lot that measured 9" by 16" and was 1 1/2" deep creating an unsafe environment. 4. Observation on 9/3/15 at 6:03 PM showed a pot hole in the parking lot that measured 54" by 32" and was 1 1/2" deep creating an unsafe	F 465	Corrective Action: The noted areas of the parking lot will be filled and/or resurfaced. The leak on the ice machine has been repaired. The sharps container hanging on the wall in the east shower room on the second floor was removed. Identification of Others: The Maintenance Director/Designee will conduct a facility-wide audit to confirm the facility is free from standing water on the floor, as well as an audit of the facility grounds to confirm that no other holes are present in the parking lot or surrounding areas. The Director of Nursing/Designee will conduct a facility-wide audit to confirm that sharps containers do not contain razors visible above the fill line.	

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F 465	Continued From page 39 environment. 5. Observation on 9/3/15 at 6:04 PM showed a pot hole in the parking lot that measured 38" by 48" and was 2 1/2" deep creating an unsafe environment. 6. Observation on 9/3/15 at 6:05 PM showed a pot hole in the parking lot that measured 62" by 36" and was 4" deep creating an unsafe environment. 7. Observation on 9/3/15 at 6:05 PM showed a pot hole in the parking lot that measured 91" by 45" and was 4" deep creating an unsafe environment. 8. Observation on 9/3/15 at 6:06 PM showed a pot hole in the parking lot that measured 38" by 12" and was 2" deep creating an unsafe environment. 9. Observation on 9/3/15 at 6:07 PM showed a pot hole in the parking lot that measured 37" by 52" and 1 1/2" deep creating an unsafe environment. 10. Observation on 9/3/15 at 6:08 PM showed a pot hole in the parking lot that measured 43" by 44" and was 4" deep creating an unsafe environment. 11. Observation on 9/2/15 at 3:58 PM showed the ice machine storage room had standing water covering the floor creating an unsafe environment. 12. Observation of the east shower room on 2nd floor on 9/3/15 at 10:19 AM showed a sharps container was hanging on the wall and razors in	F 465	System Changes: Maintenance Director will be in-serviced in regards to proper repair and maintenance of equipment and grounds. The Maintenance Director/Designee will incorporate into the preventative maintenance program a review for pot holes in the parking lot and routine reviews to assess for standing water in the facility. The Director of Nursing/Designee will routinely inspect the razor levels in sharp containers and confirm the razors are not present above the fill line. Monitoring: A QA tool will be used by ED/designee to ensure that items are being repaired and maintained. This will be reviewed at monthly QA meeting. .	

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F 465	Continued From page 40 the container were visible above the fill line creating an unsafe environment. 13. Interview with the maintenance director on 9/3/15 at 4 PM revealed the facility was aware of the pot holes in the parking lot and the water in the ice room, however, no plan had been developed to fix either area. 14. Interview with the maintenance director on 9/3/15 at 4:40 PM confirmed the areas were a safety risk to residents, employees, and visitors.	F 465	F468 Corrective Action: The hand rails will be securely fastened to the wall as to alleviate any unstableness.	10/18/2015
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This Requirement is not met as evidenced by: Based on observation and staff interview, the facility failed to equip corridors with firmly secured handrails for 2 of 3 floors (2nd, 3rd) in the facility. The findings were: 1. Observation on 9/1/15 at 10:31 AM showed the handrail outside of room 208 was not firmly secured to the wall. 2. Observation on 9/1/15 at 10:35 AM showed the handrail outside the employee bathroom on 2nd floor was not firmly secured to the wall. 3. Observation on 9/1/15 at 10:39 AM showed the handrail outside the unit manager's office on 2nd floor was not firmly secured to the wall. 4. Observation on 9/3/15 at 10:45 AM showed the handrail between room 321 and room 322 was not firmly secured to the wall.	F 468	Identification of Others: The Maintenance Director/Designee will conduct a facility-wide audit to confirm that all handrails are securely fastened. System Changes: Maintenance Director will be in-serviced in regards to the importance of ensuring hand rails are well maintained and monitored The Maintenance Director/Designee will incorporate into the preventative maintenance program an inspection of handrails to confirm they are securely fastened. Monitoring:	

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F 468	Continued From page 41 5. Observation on 9/3/15 at 10:47 AM showed the handrail between room 316 and room 318 was not firmly secured to the wall. 6. Observation on 9/3/15 at 10:49 AM showed the handrail between rooms 303 and 305 was not firmly secured to the wall. 7. Interview with the Maintenance Director on 9/3/15 at 4:30 PM confirmed the handrails were not firmly secured and could cause an injury.	F 468	A QA tool will be used by ED/designee to ensure that items are being repaired and maintained. These will be performed monthly for 3 months, then bi-monthly for 6 months thereafter. This will be reviewed at monthly QA meeting.	
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 medical record review and staff interview, the facility failed to obtain an ordered diagnostic x-ray for 1 of 1 sample residents (#84) with x-ray orders. The findings were: Review of the health status note dated 8/11/15, timed 11:18 AM, revealed resident #84 had fallen on 8/10/15, and bruising to the resident's right lateral hand had been identified. The note further revealed an x-ray order had been obtained from the resident's doctor for evaluation of the hand. Review of the health status note dated 8/12/15, timed 5:45 AM, revealed "FFU [fall follow up] monitoring continues with bruising to right pinky finger will be going to have x-ray today..." Further review of the resident's medical record	F 508	F508 Corrective Action: Resident #84 has been discharged and the x-ray cannot be completed. Discharge instruction to the accepting facility included the order for the x-ray. Identification of Others: All x-ray orders were reviewed, no other x-rays were not completed. The Director of Nursing/Designee will conduct a facility-wide audit to confirm that all orders written within 30 days for diagnostic testing are noted, scheduled, performed, and results obtained.	10/18/2015

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F 508	Continued From page 42 failed to show x-ray results. Interview with the administrator on 9/3/15 at 3:50 PM revealed the x-ray had not been done as ordered.	F 508	System Changes: Education was provided to the transport driver and nursing staff, to include the process for ordering documenting on the master calendar. The Director of Nursing/Designee will conduct random weekly audits for 90 days to confirm that all orders for diagnostic testing are noted, scheduled, performed, and results obtained. Monitoring: A QA tool will be implemented and completed by the DNS/designee 3x week x 30 days and weekly for 60 days thereafter with results taken to monthly QA for identification of trends and recommendation for a lesser frequency.	