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WY Dept of Health
OCT 29 2015
Healthcare Licensing and Surveys

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING ____ B. WING ____	C 09/11/2015

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

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F 000	INITIAL COMMENTS A complaint survey was conducted at the facility from 9/6/15 through 9/11/15. The survey was prompted by complaint intakes #WY00002097, #WY00002098, #WY00002101, #WY00002104, and #WY00002106. The following common abbreviations are used throughout this document: ADLs - Activities of daily living BIMS - Brief Interview for Mental Status CNA - Certified nurse aide DON - Director of Nursing MAR - Medication Administration Record MDS - Minimum Data Set LPN - Licensed Practical Nurse PRN - Pro re Nata (as needed) RN - Registered nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	F 157 Corrective Action: Resident #40 was discharged on 6/20/15. ID of Others: Newly admitted residents in the last 30 days will be reviewed and any skin issues will be reported to the MD. Systemic Measures: Education will be provided to nursing staff on or before 10/19/15 regarding proper physician notification with a change in condtion. The IDT will review any resident's with change of condition daily during the am clinical meeting Monday thru Friday.	10/19/15 10/28/15
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse	F 157	A weekly audit will be conducted by DON/Designee on new admissions to ensure appropriate physician notification with a change in condition weekly x4 and monthly x3. Monitoring: Nursing/designee will track and trend the results of audits completed and report findings to the QAPI committee The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: April Montoya NHA
TITLE
(X6) DATE: 10/8/15

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.

April Montoya NHA 10/29/15

POC accepted with changes. Call to Kristin Montoya, NHA on 10/30/15 @ 11:05a.
POC - 10/30/15 [illegible] RN

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F 157	Continued From page 1 consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to notify the physician of a change of condition for 1 of 11 sample residents (#40) reviewed for change of condition. The findings were: 1. Review of the nursing admission intake form dated 4/9/15 showed upon admission resident #40 had bruising on the left wrist, bruising to the left anticubital area, and rough, dry skin on the heels of both feet. 2. Review of the head to toe skin checks form for the month of April 2015 showed a skin check was completed on 4/16/15. This skin check showed the resident had intact skin, and bruising to both arms. There were no further skin checks recorded for the month of April 2015.	F 157		

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F 157	Continued From page 2 3. Review of the head to toe skin checks form for the month of May 2015 showed no skin checks were recorded. Review of the May 2015 MAR showed skin checks were to be completed on 5/7/15, 5/14/15, 5/21/15 and 5/28/15, however, none of these skin checks were initialed in the MAR as having been completed. 4. Review of the 4/25/15 nursing daily skilled summary showed the resident had a "red peri area [genital area]." 5. Review of the 4/26/15 nursing daily skilled summary showed the resident's groin was red. 6. Review of the 5/10/15, 5/16/15, 5/17/15, 5/18/15, 5/19/15, 5/22/15, 5/23/15, 5/24/15, 5/25/15, 5/26/15, 5/27/15, 5/28/15, 5/29/15, 5/30/15, and 5/31/15 nursing daily skilled summaries showed the resident had a rash to the groin. 7. Further review of the medical record failed to show any evidence the resident's physician was contacted regarding the resident's groin rash. 8. Interview with the regional director of clinical services on 9/11/15 at 8:45 AM confirmed the resident's physician had not been contacted regarding the resident's groin rash.	F 157		
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.	F 166		

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F 166	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on review of grievances and staff interview, the facility failed to ensure 10 of 10 resident grievances involving residents #9,#29, #49,#61,#67, #68, and #69 selected for review were effectively evaluated for resolution. The findings were: 1. Review of the grievance log showed a concern filed on 8/23/15 by resident #29. The issue was shown as the resident having witnessed another resident being "mean and hurting someone." Interview with the administrator on 9/11/15 at 12:05 PM revealed the grievance and the follow up information could not be found. 2. Review of the grievance log showed a concern filed on 7/8/15 by resident #49. The issue was shown as the resident requesting a possible room change. Interview with the administrator on 9/11/15 at 12:05 PM revealed the grievance and follow-up information could not be found. 3. Review of the grievance log showed a concern filed on 8/28/15 by resident #9. The issue was shown as "staff." Interview with the administrator on 9/11/15 at 12:05 PM revealed the grievance and follow-up information could not be found. 4. Review of the grievance log showed a concern filed on 8/12/15 by resident #9. The issue was shown as "meals cold/late." Interview with the administrator on 9/11/15 at 12:05 PM revealed the grievance and follow-up information could not be found.	F 166	F166: Corrective Action: Resident #29 is no longer at facility. Prior to discharge, an investigation was completed and reported to state. Resident #49 was interviewed regarding grievance and new concern form was completed with follow up by Administrator/Designee. Resident #9 was interviewed regarding grievances and new concern forms were filled out with follow-up completed by Administrator/Designee. Resident #67 was interviewed regarding grievance. Investigation conducted and conclusion reported to Wyoming Department of Health. Resident #68 was interviewed regarding grievance and new concern form was filled out with follow-up completed by Administrator/Designee. Stop sign in place and resident is satisfied. Resident #69 was interviewed regarding grievance and NHA followed up with family during care conference with satisfactory results.	9/10/15 10/29/15 9/14/15 9/10/15 9/14/15

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F 166	Continued From page 4 5. Review of a grievance filed by resident #67 on 8/6/15 showed the resident was concerned that two named employees were embezzling his/her money. This grievance was not thoroughly reviewed or investigated. There was no follow-up documented on the grievance form. 6. Review of a grievance filed by resident #29 on 8/17/15 showed the resident was concerned about a night CNA who was "rude." According to the grievance, the aide would come in and turn off the light saying she would be back, not allowing the resident to finish saying what s/he needed. There was no investigation into this concern. The aide was not named on the concern intake and there was no indication anyone attempted to discover who the aide was or if others were having the same issue. 7. Review of the grievance filed on 8/28/15 by resident #29 showed a night aide was "very rude." In the grievance the resident provided details which would allow the specific aide to be identified. The follow-up failed to identify the aide or investigate the concern further. The plan was to provide education to the aides; however, there was no evidence this was done. 8. Review of the 8/25/15 grievance filed by resident #68 showed a concern related to a wandering resident who came into the resident's room. The follow-up showed the customer service director spoke to the staff about re-directing the resident. There was no further investigation or actions taken. The concern form failed to include if the person filing the concern was satisfied with the results. 9. Review of a grievance dated 8/6/15 from	F 166	Resident #61 was interviewed regarding grievance. Investigation conducted with follow-up completed by Administrator. ID of Others: NHA/Designee will review all concern forms from the last 30 days for additional investigation and follow-up needed for thorough review. Concern log will be updated to reflect current concern forms. Systemic Measures: Customer Service Director/Designee will provide education to facility staff regarding concern process on or before Division Director of Customer Service/Designee will provide education to IDT regarding additional information and follow-up needed for thorough review of concern forms on or before NHA/Designee will audit concern forms to ensure they have been followed up on and resolved to resident safisfaction weekly x4 and monthly x3. Monitoring: Customer Service Director/designee will track and trend the results of audits completed and report findings to the QAPI committee	~~9/24/15~~ ~~10/5/15~~ ~~10/19/15~~ 10/19/15

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F 166	Continued From page 5 resident #69 showed 2 named CNAs were rushing through cares, which made the resident physically uncomfortable. The recommended action included providing additional training to the staff on transfers and cares. However, there was no evidence the education was provided, and there was no follow up with the resident to ensure the issue was resolved. 10. Review of a grievance dated 8/11/15 from resident #61 showed the resident was missing money. It further showed her laundry would be searched and a lock box would be provided when available. Interview with the administrator on 9/11/15 at 12:05 PM revealed the money was found the next day, but there was no evidence the lock box was provided or that the facility followed through with the resident to ensure the issue was fully resolved. 11. Interview with the DON on 9/11/15 at 12:05 PM revealed the grievance process was not being completed as expected and there was additional investigation and follow through needed on the concerns which were reviewed.	F 166	The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance. F225 Corrective Action: The two allegations regarding resident #35 has been thoroughly investigate by NHA/Designee and reported to the state. The allegation that resident #67 reported was thoroughly investigated by NHA/Designee and reported to the state. ID of Others: NHA/Designee will audit grievances and nurses notes for the last 30 days for all potential reportable occurrences to ensure they have been investigated and reported. Systemic Changes: District Clinical Nurse Consultant/Designee will provide education to IDT regarding additional information and follow-up needed for thorough review of concern forms on or before 10/19/15.	~~9/10/15~~ 9/15/15 ~~10/19/15~~
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	F 225		

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F 225	Continued From page 6 court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must 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 medical record review, review of incident and grievance information, and staff interview, the facility failed to ensure allegations of abuse, neglect and misappropriation of resident property were investigated and reported as required for 3 of 10 cases reviewed (#35, #67). The findings were:	F 225	DON/Designee will audit grievances and 24 hour report daily mon-fri x 4 weeks then weekly x 1 month and monthly x2. Monitoring: Nursing/designee will track and trend the results of audits completed and report findings to the QAPI committee The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	

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F 225	Continued From page 7 1. Review of the 5/23/15 late entry nurse's note, not timed, showed resident #35 "borrowed" money from another resident without the resident's permission. Interview with regional RN #1, and RN #1 on 9/9/15 at 2:35 PM revealed there was no written investigation or report of this allegation to the proper officials including the state survey agency. 2. Review of the 8/11/15 nurse's note timed 3:45 PM showed resident #35 "has been verbally abusive to [his/her] roommate and has intentionally done things to upset [him/her]..." Interview with regional RN #1, and RN #1 on 9/9/15 at 2:35 PM revealed there was no written investigation or report of this allegation to the proper officials including the state survey agency. 3. Review of a grievance filed by resident #67 on 8/6/15 showed the resident was concerned that two named employees were embezzling his/her money. This grievance was not thoroughly reviewed or investigated. There was no follow up documented on the grievance form. Interview with the administrator and the regional administrator on 9/11/15 at 2:25 PM verified this grievance should have been treated as an allegation of misappropriated resident funds, and reported and investigated as required.	F 225	F241 Corrective Action: Resident #64 has been receiving his meals. ID of Others: Dining Manager/Designee has observed 6 meal services to ensure all tray cards have been served. Systemic Measures: DM/Designee to conduct random audit over 5-7 meals to ensure all tray cards have been delivered weekly x4 weeks and then monthly x3. DM/Designee will provide education to facility staff regarding residents that eat outside of the dining room to ensure they get appropriate meal service. Monitoring: The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	10/26/15
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.	F 241		

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F 241	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident interview, and staff interview, the facility failed to provide care in a manner that maintained resident dignity for 1 of 37 open sample residents (#64). The findings were: Continuous observation of resident #64 on 9/6/15 from 5:50 PM until 7:05 PM showed the resident was seated in a wheelchair in the lobby near the north nurses' station. Interview with the resident at that time revealed s/he was waiting for the evening meal. The resident stated the facility usually brought meals to him/her wherever s/he was in the facility at mealtime. The resident remained under observation, and remained in the lobby. By 7:03 PM, the resident still had not received a meal. Interview with the resident at that time confirmed the resident had not received a meal. Interview with dietary aide #1 at 7:08 PM confirmed all meal trays had been delivered. At 7:31 PM, the resident was tearful and refused to talk. During interview at 7:33 PM, the dietary manager stated he had been told by his staff the resident's tray had been delivered to his/her room, and the resident was in the room at the time the tray was delivered. The dietary manager also stated the resident's tray would have been delivered "no earlier than 6:15 PM."	F 241		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE	F 250		

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F 250	Continued From page 9 The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record and in-house communication review, and resident and staff interview, the facility failed to ensure medically-related social service issues were addressed for 2 of 3 sample residents (#47, #50) with these types of needs. The findings were: 1. Review of the 5/29/15 in-house communication note showed a request for resident #47 to be transferred to the necessary destinations for an eye examination and a dental appointment. Review of the eye examination visit orders showed the resident was seen and fitted for new glasses on 6/24/15. The medical record review failed to show any dental appointment was made. The following concerns were identified: a. Interview with the resident on 9/8/15 at 10:30 AM revealed the resident had not been to the dentist and was having jaw discomfort. Also the resident revealed the eye exam had occurred 2-3 months previously, and s/he still did not have the glasses. b. Interview with the social service director (SSD) on 9/9/15 at 9:25 AM revealed she was not aware of this issue with the resident's glasses. She also verified the resident had not yet been to a dental appointment. An appointment had been scheduled and was canceled due to transportation issues. The rescheduled	F 250	F250 Corrective Action: Resident #47 received eye glasses on 9/9/15 and was seen by the dentist on 9/30/15. Resident #50 received eye glasses on 9/23/15 ID of Others: Social Services/Designee conducted a facility wide audit for unmet dental and vision needs. Systemic Changes: Social Services/Designee will conduct an audit mon-fri for eye and dental follow-up daily x 4weeks then weekly x 4 then monthly x2. Monitoring: Social Services/Designee will bring audit results to QAPI meeting.The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	10/19/15

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F 250	Continued From page 10 appointment was set for 9/30/15. The SSD further verified it was discovered on 9/9/15 the facility had not previously explored how the glasses would be paid for. 2. Review of the medical record showed an eye exam was completed, and an estimated cost sheet for new glasses was included from a 2/6/15 visit for resident #50. Observation during the survey from 9/6/15 to 9/11/15 showed the resident did not wear glasses. Interview with the SSD on 9/9/15 at 9:25 AM revealed she was not aware the resident needed glasses. The SSD further verified it was discovered on 9/9/15 the facility had not previously explored how the glasses would be paid for, so the glasses had not been received by the resident.	F 250	F253 Corrective Action: Activity/Dining area has been thoroughly cleaned and swept and is free from dust, crumbs and debris by housekeeping/designee. Black mat located outside the entrance doors has been cleaned by housekeeping/designee. Resident dining chairs in the north dining room have been cleaned by housekeeping/designee. Carpet in the front hallway, including in front of room #117 have been cleaned by housekeeping/designee.	10/14/15
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure housekeeping services were provided to maintain a clean and sanitary environment in 2 of 6 resident areas (the activity room, the front hallway). The findings were: 1. Observation on 9/7/15 at 11:47 AM showed the activity room, which also served as a dining room, was not well cleaned. The area around the edge of the room was not swept and there was an accumulation of dust, crumbs, and debris. The	F 253	ID of Others: Maintenance Assistant/Designee completed facility wide audit to ensure carpeted areas were clean. Maintenance Assistant/Designee completed facility wide audit to ensure floors were clean. Maintenance Assistant completed audit of dining areas to ensure chairs were clean. Systemic Changes: Enviromental rounds will be completed to ensure carpets, floors and chairs are being kept clean by NHA/Designee weekly x4 weeks then monthly x 3 months. Monitoring:	

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CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

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F 253	Continued From page 11 black mat located by the outside entrance doors was unclean with dirt, and bits of paper debris. Additionally, in this room there were 3 resident dining chairs noted to be soiled with dried on foods/liquids. Observation on 9/11/15 at 3:10 PM showed the conditions of the chairs and the floors remained unclean. Interview with an activity aide on 9/11/15 at 3:15 PM revealed housekeeping was responsible for cleaning the room, including the chairs and floors. 2. Observation of the front hallway on 9/7/15 at 10:42 AM showed the carpet was soiled with discolored areas from dried spills. Observation on 9/8/15 at 9:55 AM near the entrance to resident room 117 showed a circular area of dried matter brown in color approximately 5 inches across that was crunchy when stepped on. The overall condition of the carpet in the front hallway appeared unclean. The carpet remained in that condition throughout the survey which ended on 9/11/15. 3. Interview with the administrator on 9/11/15 at 3:30 PM verified the housekeeping services were provided through contract and there were at least two employees out due to injuries/illness. The administrator verified the shortage of staff contributed to the unclean areas.	F 253	Maintenance Assistant/designee will track and trend the results of audits completed and report findings to the QAPI committee The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance. F279 Corrective Action: Resident #28 care plan has been updated by Don/Designee to reflect una boot and wound clinic visits on 9/8/15 Resident #27 care plan has been updated to address current skin conditions and current treatment plan by DON/Designee on 9/8/15. Resident #25 Discharged on 4/24/15.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279	Resident #9 Care plan was updated 9/14/15 by DON/Designee to reflect required assistance and supervision with meals. ID of Others: DON/Designee will review residents with current pressure ulcers to ensure care	

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F 279	Continued From page 12 objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to develop a comprehensive care plan for 4 of 37 open sample residents (#9, #25, #27, #28). The findings were: 1. Observation on 9/7/15 at 11:55 AM showed resident #28 had an Unna boot (supportive dressing boot) on his/her left lower leg. Interview with the resident on 9/7/15 at 1:20 PM showed s/he had a wound resulting from a spider bite prior to being admitted to the facility on 5/6/15 and was being treated for the wound once weekly at a local wound clinic. Care plan review showed the resident had a plan for non-pressure wounds. The following concerns were identified: a. Care plan review showed the facility failed to address the resident's wound clinic visits, the Unna boot, and what (if anything) facility staff should do for the resident's wound between wound clinic visits if the resident's Unna boot	F 279	plans reflect current status of wound and wound interventions. DON/Designee will review fall care plans for resident whom have fallen in the last 30 days to ensure appropriate they reflect current interventions. DON/Designee will review ADL care plans for resident who require assistance with meals to ensure this is reflected. Systemic Changes: RCMD/designee will audit care plans weekly x 3, then monthly x 4 for falls, wound care interventions and any dining assistance required. District Director of Care Manager (DDCM), or designee, will educate the IDT on care plan completion and updating. Monitoring: Nursing/designee will track and trend the results of audits completed and report findings to the QAPI committee The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	10/19/15

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F 279	Continued From page 13	F 279		

came off or was soiled or restricting.

b. Interview with wound care nurse #1 on 9/8/15 at 2:45 PM confirmed the resident's care plan failed to address areas of care concerning the resident's wound.

2. Observation on 9/8/15 at 6:50 PM showed CNA #4 and CNA #5 transferred resident #27 to bed with a mechanical lift. The observation showed the resident had 2 pressure ulcers, one at the sacral area and one at the right mid-gluteal area. The 2 pressure ulcers had no dressing at that time. In addition, the resident's right outer hip area was visibly reddened. Medical record review showed a 3/20/15 Braden Scale assessment (assessment for pressure ulcer risk) that scored an 11 (high risk). Review of the resident's care plan showed a plan for pressure ulcers. The following issues were identified:

a. Care plan review showed a plan for pressure ulcers last updated on 9/2/15. The plan failed to address both pressure ulcers, with the last specific documented date of 7/31/15 for "Healing ST [stage] 3 R [right] ischial ulcer." The care plan showed the resident had actual pressure ulcers, but the plan documented a 3/28/15 Braden Score of 17 (not at high risk). The facility failed to update the plan to include the 8/11/15 physician order for a hydrocolloid dressing to the right buttock, and an order on 8/22/15 to continue to apply hydrocolloid dressings for pressure ulcers. The last dressing update on the care plan was dated 7/13/15 for "Duoderm to right ischium."

b. Interview with wound care nurse #1 on 9/7/15 at 12:50 PM confirmed the resident's care plan should include both pressure ulcers, the reddened area on the right hip that she stated was "currently unstageable," and current

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F 279	Continued From page 14 treatment orders for all pressure ulcers. 3. Review of the 3/22/15 post fall review showed resident #25 had fallen asleep in his/her wheelchair in the hallway, had fallen out of the chair and was found at 9:45 PM. The resident was found sleeping on the floor in the hallway outside his/her room. The summary of the interdisciplinary team dated 3/23/15 showed physical therapy would evaluate the wheelchair positioning for possible dumping, and nursing would continue to monitor for pain. A new fall risk evaluation was completed on 3/23/15 and the resident scored "20," which was high risk for falls. Review of the resident's care plan for falls showed it was initiated on 3/11/15. There was a date of 3/23/15 in the reviewed column; however, no new interventions were shown. Interview with RN #2 on 9/11/15 at 11:05 AM verified the fall review was not thorough and there were no interventions had been developed to add to the care plan. 4. Review of the 7/16/15 significant change MDS assessment for resident #9 showed s/he required extensive assistance with all ADLs due to Parkinson's Disease. Review of the 8/1/15 speech therapist note showed the resident must not eat alone. Review of the 8/5/15 speech therapist discharge note showed the highest practical level had been achieved, the resident tolerated mechanical soft solids, extra gravies and thin liquids with functional oral skills, no overt clinical signs and symptoms of aspiration, and needed occasional verbal reminders for alternating liquids and solids for clearance. Additionally, staff were required to provide assistance at all meals "due to choking risk," and the resident must not eat alone. Review of the	F 279		

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F 279	Continued From page 15 care plan showed the resident required assistance with eating due to swallowing difficulties, but instructions about not allowing the resident to eat alone due to choking risks had not been included. The following concerns were identified: a. Observation on 9/7/25 at 12:35 PM showed CNA #7 placed the lunch tray on the resident's over-bed table in his/her room and departed. The food items were within the resident's reach. The resident grasped the cup off the tray, then replaced it, and only stared at the food. At 12:50 PM a second CNA entered the room and began to feed the resident (15 minutes later). Further observation of the meal showed the resident occasionally coughed and the CNA gave verbal cues to eat slowly. b. Observation on 9/9/15 at 11:50 AM revealed staff were not present in the room when the resident grasped the banana on the over-bed table, positioned it in both hands, then put it back on the over-bed table. At that time s/he stated "I will eat it later." c. Observation on 9/9/15 at 6 PM revealed the resident was sitting upright in bed while repositioning a sandwich and bag of pepperoni slices on the over-bed table. The resident was alone in his/her room. e. Interview on 9/11/15 at 2:30 PM with CNAs #8 and #9 revealed they were aware staff had to feed the resident and allow him/her to do as much as s/he could independently. f. However, neither CNA was aware of the instructions to never let the resident eat alone. Review of nurse's documentation from 7/3/15 to 9/8/15 revealed the resident continued to have swallowing problems, but there had been no episodes of choking or food/liquids obstructing his/her airway.	F 279		

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F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure physician orders were followed for 5 of 37 open sample residents (#30, #32, #51,#63, #70). The findings were: 1. Review of the admission orders showed resident #30 was re-admitted to the facility on 5/19/15 with diagnoses that included chronic obstructive pulmonary disease and congestive heart failure. The following concerns were identified: a. Review of the physician telephone orders dated 5/20/15 showed the following order related to oxygen: "__ LPM 02 via NC [liters per minute of oxygen via nasal cannula]." b. Interview with RN #2 on 9/9/15 at 5:15 PM revealed there was no indication on the order form for how many liters of oxygen the resident was to receive. She further confirmed there was no evidence the physician was contacted to clarify the order and she was unsure of how many liters per minute of oxygen the resident should have received. 2. Review of the 5/19/15 care plan for resident #70 revealed the resident had dementia, and increased weakness due to multiple sclerosis. Further review showed s/he required extensive assistance with ADLs and had fallen in the past. Review of the 2/12/15 and 5/19/15 fall risk	F 281	F281 Corrective Action: Resident #30 no longer resides at the facility. A therapy evaluation has been completed for Resident #70. Resident #51 is currently receiving medications as ordered. Resident #32 is currently receiving medications as ordered. Resident #63 is currently receiving medications as ordered. ID of Others: DON or designee will review the residents who have oxygen in order to ensure that the liters are clearly specified for each resident. DON or designee will audit physician's orders for the past 30 days to ensure any therapy orders have been initiated, and antibiotics given as ordered. If not, medication variances will be completed. Systemic Measures: DON or designee will review physician's orders daily for therapy orders to validate	10/19/15 jr

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F 281	Continued From page 17 assessments showed the resident was at risk for falls. The following concerns were identified: a. Review of the physician's order, dated 5/15/15, showed an order for physical and occupational therapy to evaluate and treat for decline in ADLs and weakness. b. Review of the medical record showed no evidence the order for physical and occupational therapy evaluation was carried out. c. Interview with the physical therapist on 9/8/15 at 12:20 PM revealed the evaluation and treatment had not been done because the order had not been communicated to the therapy staff. She stated the nurses usually told the therapy staff about therapy orders, but this one was missed. 3. Review of physician orders for resident #51 showed an order dated 7/12/15, untimed, for Keflex (an anti-microbial medication) 250 mg to be given by mouth four times daily for 10 days as treatment for a urinary tract infection. Review of the resident's MAR for July 2015 showed the first dose of the medication was administered at 6 PM on 7/12/15. Further review showed only 33 of the 40 doses ordered were initialed as having been administered. 4. Review of physician orders for resident #32 showed an order dated 6/18/15, timed 5:45 PM, for Keflex 500 mg to be given four times daily for 10 days as treatment for cellulitis. Review of the resident's MAR for June 2015 showed the first dose of the medication was given at 8 PM on 6/18/15. Further review showed the 8 AM and 12 PM doses that were to be administered on 6/25/15 were not initialed as having been administered; only 38 of the 40 ordered doses were initialed as having been administered.	F 281	initiation, antibiotics to ensure they are given, and oxygen orders, Monday-Friday x 4 weeks, then weekly x 4 weeks, then monthly x 2. Monitoring: Nursing/designee will track and trend the results of audits completed and report findings to the QAPI committee. The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	

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F 281	Continued From page 18 5. Review of physician orders for resident #63 showed an order dated 5/28/1/5, timed 4:30 PM, for Keflex 500 mg to be given by mouth three times daily for 10 days as a treatment for a skin infection. Review of the resident's MARs for May and June 2015 showed only 29 of the 30 ordered doses were initialed as having been administered. 6. Interview with RN #2 on 9/11/15 at 8:50 AM confirmed the facility should be recording and investigating a medication error every time a medication is omitted. Further, she confirmed physician orders should be followed as written. 7. Interview with regional RN #1 on 9/11/15 at 10:35 AM confirmed the facility was unable to locate any documentation on medication errors in the facility and was unable to determine why the medication doses were omitted, or if the facility had investigated the errors.	F 281	F 309 Resident #30 no longer at the facility. Resident #51 is currently receiving medications as ordered. Resident #32 is currently receiving medications as ordered. Resident #63 is currently receiving medications as ordered. Resident #28 is receiving wound care as ordered. Resident continues to be seen by wound healing clinic and continues to be followed by the MD. Resident #11 is receiving pain medications as ordered and/or as requested.	10/19/15
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure	F 309	Resident #1 has been discharged from the facility. ID of Others: DON or designee will audit physician's orders for the past 30 days to ensure antibiotics given as ordered. If not, medication variances will be completed. Review of all residents with current wounds for treatment order to ensure that they are clear, specifically if receiving treatment from outside the facility.	

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F 309	Continued From page 19 adequate care in the following areas: assessment and treatment for 1 of 11 sample residents (#30) with a change in condition, resulting in further decline; adequate coordination of care for 1 of 1 sample resident (#28) who had a non-pressure wound; adequate medication administration for 3 of 37 sample residents (#32, #51, #63); adequate pain interventions for 1 of 14 sample residents (#11) who had pain issues; and adequate post-fall neurological assessments for 1 of 3 sample residents (#1) who had falls that required neurological assessments. The findings were: Concerns with the assessment and treatment of a resident with a change in condition: 1. Review of the situation background assessment recommendation (SBAR) communication form dated 6/14/15 showed resident #30 was found in his/her room by a nurse to be "blue in the face with altered LOC [level of consciousness] SOB [short of breath] with increased respirations." The resident's vital signs were taken at that time and showed his/her blood pressure was 208/124, pulse rate was 114 beats per minute, respirations were 24 breaths per minute, and oxygen saturation level was 50% on 4 liters per minute of oxygen via nasal cannula. Further review showed the resident had increased confusion, abnormal lung sounds, and slurred speech. Immediate interventions included repositioning, a nebulizer treatment with instructions for breathing out through pursed lips, and a non-rebreather mask. The note stated the resident was "rapidly improving," with a blood pressure of 185/93, pulse rate of 92, respiration rate to 22, and oxygen saturation level of 93%. Additional intervention included "Res [resident] educated on smoking cessasion (sic)." Review of	F 309	The facility will review the 24 hour report for the past 30 days. Any changes in condition will be reviewed in order to ensure that the physician was notified, and that any interventions were completed, and any education needed will be conducted. An audit will be completed for all falls over the past 30 days. Any neurological assessment that was not completed correctly will be communicated to the physician. Any falls that were not followed-up on appropriately will be communicated to the physician. DON/designee will review any residents with narcotic pain medications ordered to determine availability. Any medications that are unavailable will be ordered STAT from the pharmacy or pulled from the e-kit. Systemic Changes: DON/designee will review physician's order and 24-hour report on random shifts and units, for new antibiotic orders, changes in wound care orders, and falls, as well as change in conditions. DON/designee will conduct audit on different shifts and units by utilizing the 24-hour reports, physician's orders and PCC dashboard to ensure antibiotics are given as ordered, wound care is completed as ordered and clarified as needed, neurochecks are completed for	10/14/15

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F 309	Continued From page 20 the 4/12/15 admission MDS assessment showed the had diagnoses that included chronic obstructive pulmonary disease, congestive heart failure, hypertension, and anxiety. The following concerns were identified: a. Further review of the 6/14/15 SBAR communication form indicated the physician was notified of the resident's change of condition on that date; however, there was no indication of how the physician was notified, or whether the physician responded to the notification. b. Review of physician's orders failed to show any evidence the physician received the notification or provided orders related to the elevated blood pressure, abnormal lung sounds, altered level of consciousness, decreased oxygen saturation, or increased confusion. c. Review of the physician orders dated 6/9/15 showed Duoneb 0.5 mg- 3 mg (2.5 mg/ 3 mL) solution every four hours as needed for shortness of breath. Review of the physician orders dated 5/20/15 showed the following order related to oxygen: "__ LPM 02 via NC [liters per minute of oxygen via nasal cannula];" however, no value was given to indicate how many liters per minute, or parameters for oxygen titration to maintain the resident's oxygen saturation levels within a specified range. Review of the daily skilled summary sheets dated daily from 5/23/15 to 6/6/15 showed the resident was receiving 4 liters of oxygen via nasal cannula daily. d. Review of the nurse's note dated 6/15/15 and timed 12-6 am shift showed the resident had no concerns other than "s/he states s/he is really tired and feels like s/he slept most of the day." The note further indicated the resident received nebulizer treatments two times which the resident stated "helped [him/her] out very much." Additionally, the resident's oxygen saturation level	F 309	any applicable falls, and any changes in condition are addressed with MD and any timely and appropriate interventions. DON/designee will audit residents who have pain medications ordered, 3x/week x 4 weeks, then monthly x 3 to ensure narcotic availability and being administered as ordered. DON/designee will educate nursing staff on or before 10/19/15 regarding following physician orders, completion of neurochecks, and identifying changes of conditions and follow through. Monitoring: Nursing/designee will track and trend the results of audits completed and report findings to the QAPI committee. The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	

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F 309	Continued From page 21 was recorded at 94% on 3 liters of oxygen via nasal cannula. e. Review of the nurse's note dated 6/16/15 and timed 8:35 PM showed the resident "continues to have anxiety d/t [due to] breathing difficulties. Breathing treatments given and are effective." Further review showed the space to record the resident's oxygen saturation level was left blank. f. Review of the nurse's note dated 6/17/15 and timed 12:30 PM showed the resident "continues to be anxious about oxygen levels and [his/her] breathing." Further, it revealed "often times res [resident] is found out in the hallway without [his/her] O2 on." The note records the resident's oxygen saturation level was 95%. g. Review of the medical record showed no notes or vital signs, including oxygen saturation level, were recorded for the resident on 6/18/15 prior to a nurse's note timed 9 PM showed the resident was "absent of vitals" and pronounced dead. h. Interview with RN #2 on 9/9/15 at 5:15 PM confirmed there was no evidence the doctor received the 6/14/15 SBAR communication or provided orders regarding the change in condition. She revealed the facility did not pursue additional assessments or increase monitoring of the resident as the oxygen saturation levels were above 90% and they "felt things were better" with the resident. She further confirmed there was no indication on the physician order form for how many liters of oxygen the resident was to receive, or parameters for oxygen titration to maintain the resident's oxygen saturation levels within a specified range. She revealed there was no evidence the physician was contacted to clarify the order and she was unsure of how many liters per minute of oxygen the resident should have received. Concerns with non-pressure wounds:	F 309		

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F 309	Continued From page 22 Observation on 9/7/15 at 11:56 AM showed resident #28 had an Unna boot (supportive dressing boot) on his/her left lower leg. Interview with the resident on 9/7/15 at 1:20 PM showed s/he had a wound resulting from a spider bite prior to being admitted to the facility on 5/6/15 and was being treated for the wound once weekly at a local wound clinic. Medical record review showed a 6/8/15 physician order for facility treatment of the resident's wound. The review showed several changes to the physician orders for care of the resident's wound until a 7/12/15 physician order to have a local wound clinic evaluate and debride the wound. The final physician order of 8/11/15 stated, "Cleanse wound on pt. (L) [patient's left] lower leg with NS [normal saline] and dress with silver and foam once every 2-3 days and prn [as needed] to maintain C/D/I [clean/dry/intact] dressing. Please assist patient with application of compression stocking to left LE [lower extremity]. Should wear stocking while OOB [out of bed]." The following concerns regarding coordination of the resident's wound care were identified: a. Medical record review showed the facility failed to include documentation for the weekly wound clinic visits with the exception of the 8/12/15 visit when wound cultures were obtained and an Unna boot was applied. During the survey, on 9/8/15, wound care nurse #1 called the wound clinic and received the documentation for those visits. b. Physician order review showed the 8/11/15 order for wound care every 2-3 days was not discontinued. However, review of the entire medical record showed the facility did not complete this order after the Unna boot was applied to the resident's left lower extremity on	F 309		

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F 309	Continued From page 23 the 8/12/15 wound clinic visit. c. Care plan review showed the facility failed to address the resident's weekly wound clinic visits, the Unna boot on the resident's left lower extremity, compression stockings, and what (if anything) facility staff should do for the resident's wound between wound clinic visits if the resident's Unna boot came off, or was soiled or restricting. d. Interview with wound care nurse #1 on 9/8/15 at 2:45 PM confirmed the facility failed to coordinate care of the resident's wound with the wound clinic. She further confirmed the facility failed to clarify the physician order of 8/11/15 for wound care every 2-3 days and PRN. Finally, she confirmed the resident's care plan failed to address areas of care concerning the resident's wound including weekly wound clinic visits, the resident's Unna boot, compression stockings and any guidance to facility staff for care of the resident's wound between weekly wound clinic visits. Concerns with medication administration: 1. Review of physician orders for resident #51 showed an order dated 7/12/15, untimed, for Keflex (an anti-microbial medication) 250 mg to be given by mouth four times daily for 10 days as treatment for a urinary tract infection. Review of the resident's MAR for July 2015 showed the first dose of the medication was administered at 6 PM on 7/12/15. Further review showed only 33 of the 40 doses ordered were initialed as having been administered. 2. Review of physician orders for resident #32 showed an order dated 6/18/15, timed 5:45 PM, for Keflex 500 mg to be given four times daily for	F 309		

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F 309	Continued From page 24 10 days as treatment for cellulitis. Review of the resident's MAR for June 2015 showed the first dose of the medication was given at 8 PM on 6/18/15. Further review showed the 8 AM and 12 PM doses that were to be administered on 6/25/15 were not initialed as having been administered; only 38 of the 40 ordered doses were initialed as having been administered. 3. Review of physician orders for resident #63 showed an order dated 5/28/1/5, timed 4:30 PM, for Keflex 500 mg to be given by mouth three times daily for 10 days as a treatment for a skin infection. Review of the resident's MARs for May and June 2015 showed only 29 of the 30 ordered doses were initialed as having been administered. 4. Interview with RN #2 on 9/11/15 at 8:50 AM confirmed the facility should be recording and investigating a medication error every time a medication is omitted. 5. Interview with the regional director of clinical services on 9/11/15 at 10:35 AM confirmed the facility was unable to locate any documentation on medication errors in the facility and was unable to determine why the medication doses were omitted, or if the facility had investigated the errors. Concerns with pain interventions: 1. Review of the 7/10/15 annual MDS assessment for resident #11 showed the resident had pain frequently and received scheduled and prn (as needed) pain medication. Review of the 7/29/15 care plan showed the resident had shoulder joint pain, and approaches included:	F 309		

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F 309	Continued From page 25 administer pain medication, observe for signs and symptoms of pain, and monitor every shift. Further review of the care plan showed the resident did not usually verbalize pain and non-verbal signs included crying and rubbing his/her arm. Review of the physician's orders showed Percocet 5 mg-325 milligrams (medication for pain) three times a day was ordered on 5/14/15. Further review also showed an order for Tylenol prn every four hours. The following concerns were identified: a. Review of the September 2015 MAR showed staff did not administer the Percocet on 9/1/15, 9/2/15 and 9/3/15 because the medication was not available. b. Review of the 9/1/15 nursing notes revealed the resident was out of pain pills, cried most of the shift and was up and down in the bed throughout the night. c. Review of the September 2015 prn pain medication administration record showed prn Tylenol administered on 9/1/15, 9/2/15, and 9/3/15 was effective. Review of the September 2015 MAR showed staff resumed the Percocet as ordered on 9/4/15. d. Interview on 9/9/15 at 6:15 PM with the MDS coordinator revealed the medication was not available due to a problem with the communication between the physician and pharmacist. She stated staff had not reviewed the pain management approaches to determine whether changes were needed regarding the scheduled Percocet, since the pain assessments showed Tylenol was effective when the Percocet was not available. She further stated there might have been a variation in the way different staff assessed the resident's pain. Concerns with post-fall neurological	F 309		

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F 309	Continued From page 26 assessments: 1. Review of the MDS coordinator's 2/15/15 MDS summary nursing notes showed resident #1 required extensive assistance with ADLs, had a BIMS score of 9 (indicating moderate cognitive impairment) and occasionally could self-propel his/her wheelchair. Review of the 2/17/15 care plan showed the resident was at risk for falls due to a history of a stroke and balance problems. Review of the Interdisciplinary Post Fall Review showed the resident fell backwards in the bathroom on 2/16/15. Further review revealed the resident hit his/her head and sustained a "6 centimeter in circumference bruise and raised knot" on the left temple. Review of the post-fall vital signs showed staff assessed the resident's neurological signs at the time of the incident. However, the facility was unable to provide evidence that staff performed additional assessments as directed by the policy and procedure for recording and monitoring the neurological condition of a resident with a head injury. 2. According to the facility's policy and procedure titled "Briggs Neurological Record, 2/09": the instructions/recommendations following any injury resulting in actual or suspected head trauma, or any change in level of consciousness include neurological checks every 30 minutes x 4, hourly x 4, every 4 hours x 24 and every 8 hours for the remaining 72 hours.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314		

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F 314	Continued From page 27 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure adequate pressure ulcer care for 1 of 8 sample residents (#27) reviewed for pressure ulcers. The findings were: Observation on 9/6/15 at 6:50 PM showed CNA #4 and CNA #5 transferred resident #27 to bed with a mechanical lift. The observation showed the resident had 2 pressure ulcers, one at the sacral area and one at the right mid-gluteal area. The 2 pressure ulcers were clean and dry and had no dressing at that time. In addition, the resident's right outer hip area was visibly reddened. At that time the 2 aides informed RN #3, and the RN cleansed the 2 pressure ulcers, applied calcium alginate, and applied a hydrocolloid dressing to each. In addition, she assessed the visibly reddened area on the resident's right outer hip and applied a hydrocolloid dressing to the area. Observation on 9/7/15 at 12:50 PM showed wound care nurse #1 and LPN #1 assessed the skin of resident #27. At that time a decision was made to leave the hydrocolloid dressings to the 2 previous pressure ulcers, and also the dressing applied during the observation on 9/6/15 at 6:50 PM to the resident's right outer hip. Interview with the wound care	F 314	Corrective Action: Resident #27 is receiving wound care as ordered. Resident #27 care plan has been updated to reflect current repositioning program. Resident #27 is being repositioned according to her care plan. 10/19/15 Id of Others: DON/designee will review resident's with wound care to ensure they are receiving treatments as ordered. DON/designee will review resident's requiring repositioning program to ensure care plan reflects current repositioning program. 10/19/15 Systemic Changes: DON/designee will audit weekly x4 weeks and monthly x3, current residents who have wounds and/or require turning repositioning programs to ensure these residents receive treatments are ordered and repositioned according to current care plan. 10/19/15 Education will be provided by the DON/designee on or before 10/19/15 regarding following physician's orders for wound care treatments and repositioning according to care plan. monitoring based on compliance.	10/19/15

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F 314	Continued From page 28 nurse #1 at that time showed the original 2 pressure ulcers were identified as Stage II, and the current area on the resident's right outer hip was unstageable. Medical record review showed a 3/20/15 Braden Scale assessment (assessment for pressure ulcer risk) that scored an 11 (high risk). Review of the 8/13/15 quarterly MDS assessment showed the resident was totally dependent upon staff for personal care and transfers. Review of the resident's care plan showed a plan for pressure ulcers. The following concerns were identified: a. Observation on 9/7/15 from 12:50 PM through 3:45 PM (2 hours and 55 minutes) showed the resident remained on his/her left side in bed. Observation at 3:45 PM showed the DON and CNA #6 repositioned the resident on his/her right side. The observation showed the resident's outer left hip was visibly reddened. b. Interview with the DON on 9/7/15 immediately after the 3:45 PM observation showed her expectation was for staff to reposition the resident "every couple of hours." c. Care plan review showed a plan for pressure ulcers last updated on 9/2/15. The plan failed to address both pressure ulcers, with the last specific documented date of 7/31/15 for "Healing ST [stage] 3 R [right] ischial ulcer." The care plan showed the resident had actual pressure ulcers, but the plan documented a 3/28/15 Braden Score of 17 (not at high risk). The facility failed to update the plan to include the 8/11/15 physician order for a hydrocolloid dressing to the right buttock, and an order on 8/22/15 to continue to apply hydrocolloid dressings for pressure ulcers. The last dressing update on the care plan was dated 7/13/15 for "Duoderm to right ischium." The care plan for pressure ulcers called for, "Turn and reposition	F 314	Monitoring: Nursing/designee will track and trend the results of audits completed and report findings to the QAPI committee The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	10/28/15

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F 314	Continued From page 29 while in bed frequently for comfort and pressure reduction." The care plan for behaviors called for, "Reposition Q2 [every 2 hours] while in chair/bed."	F 314	F323 Corrective Action:	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to ensure a safe environment related to falls for 3 of 16 sample residents (#6, #9, #25). In addition, the facility failed to ensure 1 of 5 sample residents with swallowing issues (#9) had adequate supervision related to foods with inappropriate textures. Further, the facility failed to ensure a safe environment related to unsafe storage of supplies for 1 random observation (#57). The findings were: Concerns related to unsafe swallowing practices: 1. Review of the 7/16/15 significant change MDS assessment for resident #9 showed s/he required extensive assistance with all ADLs due to Parkinson's Disease. Review of the 8/1/15 speech therapist note showed the resident must not eat alone. Review of the 8/5/15 speech	F 323	Resident #6 no longer resides in the facility. Resident #9 is receiving appropriate foods with the proper texture as per physician's orders. Resident #9 is being supervised and receiving assistance during meals as required. Resident #9's fall was reviewed by the IDT and current interventions are in place. Resident #25 no longer resides in the facility. All supply closets have been secured with coded locks. ID of Others: All residents have the potential to be affected by the alleged deficient practice. DON/designee will review all falls over the past 30 days to ensure that fall investigations were completed an interventions were put into place as appropriate.	10/14/15

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F 323	Continued From page 30 therapist discharge note showed the highest practical level had been achieved, the resident tolerated mechanical soft solids, extra gravies and thin liquids with functional oral skills, no overt clinical signs and symptoms of aspiration, and needed occasional verbal reminders for alternating liquids and solids for clearance. Additionally, staff were required to provide assistance at all meals "due to choking risk," and the resident must not eat alone. Review of the care plan showed the resident required assistance with eating due to swallowing difficulties, but instructions about not allowing the resident to eat alone due to choking risks had not been included. The following concerns were identified: a. Observation on 9/7/25 at 12:35 PM revealed CNA #7 placed the lunch tray on the resident's over-bed table in his/her room and departed. The food items were within the resident's reach. The resident grasped the cup off the tray, then replaced it, and only stared at the food. At 12:50 PM a second CNA entered the room and began to feed the resident (15 minutes later). Continued observation of the meal showed the resident occasionally coughed and the CNA gave verbal cues to eat slowly. b. Observation on 9/9/15 at 11:50 AM revealed staff were not present in the room when the resident grasped the banana on the over-bed table, positioned it in both hands, then put it back on the over-bed table. At that time s/he stated "I will eat it later." c. Observation on 9/9/15 at 6 PM revealed the resident was sitting upright in bed while repositioning a sandwich and bag of pepperoni slices on the over-bed table. The resident was alone in his/her room. d. Interview on 9/11/15 at 2:30 PM with CNA	F 323	DON/Designee will review care plans of resident's with noted swallowing issues to ensure care plan reflects resident's supervision needs with food intake. 10/19/15 Systemic Changes: DON/Designee will update the CNA's Resident ADL Information sheet Monday thru Friday during the morning clinical meeting as changes occur. District Clinical Nurse Consultant or designee will provide education to the IDT, on or before 10/19/15, regarding proper fall investigations and interventions. The DON/designee will provide education to the nursing staff on or before 10/19/15, regarding proper fall investigations and interventions. And on reviewing care plans and the CNA ADL Information sheet to ensure instructions for resident's with swallowing risks are followed. 10/9/15	10/19/15

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F 323	Continued From page 31 #8 and CNA #9 revealed they were aware staff had to feed the resident and allow him/her to do as much as s/he could independently. However, neither CNA was aware of the instructions to never let the resident eat alone. e. Review of nursing documentation from 7/3/15 to 9/8/15 showed the resident continued to have swallowing problems, but there had been no episodes of choking or food/liquids obstructing his/her airway. Concerns related to falls: 1. Review of the 7/16/15 significant change MDS assessment showed resident #9 had a BIMS score of 13 (indicating the resident was cognitively intact), no behaviors, a urinary catheter, limited range of motion and required extensive assistance with all ADLs. Review of the care plan showed staff implemented approaches to prevent falls because the resident was assessed as being at high risk for falls. Review of the medical record revealed the resident fell on 6/24/15 and fractured his/her hip on 6/24/15. Further review revealed s/he had surgery at the hospital and returned to the facility on 7/3/15. The following concerns were identified: a. Interview with the resident on 9/9/15 at 11:50 AM revealed the resident was upset because s/he functioned with minimal assistance prior to 6/24/15 and now was almost totally dependent. The resident stated s/he activated the call light on 6/24/15, waited over an hour for a response, then attempted to go to the bathroom without staff assistance and fell. The resident further stated that s/he had talked with staff prior to 6/24/15 about the problem of the long wait for a response to the call light, but the situation did not get better. The resident expressed the desire to	F 323	Monitoring: Nursing/designee will track and trend the results of audits completed and report findings to the QAPI committee The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	KM 10/2/15

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F 323	Continued From page 32 maintain the post surgery urinary catheter because s/he was afraid of a recurrent incident. b. Review of the 6/24/15 interdisciplinary post fall review revealed the investigation sections had not been completed. 2. Review of the 2/6/15 quarterly MDS assessment for resident #6 showed the resident had severe cognitive impairment, required assistance with most ADLs, and was wheelchair dependent. Review of the 2/14/15 fall risk assessment showed the resident was assessed as being at high risk for falls. The following concerns were identified: a. Review of the Interdisciplinary Post Fall Reviews showed the following incidents: On 1/2/15 the resident rolled forward out of the wheelchair onto the floor. On 2/4/15 the resident fell forward from the wheelchair. On 3/7/15 the resident was found on the floor in the dining room lying on his/her back. On 5/16/15 the resident fell asleep in his/her chair and fell forward to the floor. b. Further review of the 1/2/15, 2/4/15, 3/7/15 and 5/16/15 interdisciplinary post fall reviews revealed the investigation sections had not been completed. 3. Interview on 9/11/15 at 3:30 PM with the MDS coordinator verified the investigation sections on the interdisciplinary post fall reviews for residents #6 and #9 had not been completed. 4. Review of the 3/22/15 post fall review showed resident #25 had a fall from the wheelchair, the fall was unwitnessed, and the resident was found at 9:45 PM. The review showed the resident fell asleep in the wheelchair and was found sleeping on the floor in the hallway outside his/her room.	F 323		

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F 323	Continued From page 33 The resident complained of right shoulder pain with no obvious injuries were noted. Continued review showed the resident had a diagnosis of Huntington's disease and required a full mechanical lift for transfers. The following concerns were identified: a. The summary of the interdisciplinary team dated 3/23/15 showed physical therapy would evaluate the wheelchair positioning, and nursing would continue to monitor for pain. The time of evening and the resident sleeping in the wheelchair were not reviewed as possible contributing factors to the fall. b. A new fall risk evaluation was completed on 3/23/15 and the resident scored "20," which was high risk for falls. The area of the post fall review form for intervention recommendations showed it was not completed, including the area for care plan revision. c. Review of the resident's care plan for falls showed it was initiated on 3/11/15. There was a date of 3/23/15 in the reviewed column; however, no new interventions were shown. d. Interview with RN #2 on 9/11/15 at 11:05 AM verified the fall review was not thorough and no interventions had been developed to be added to the care plan. 5. Review of the Fall Management Policy, revised August 2012, showed "when a resident is found on the floor, the facility is obligated to investigate to determine how he or she got there and put into place an intervention to minimize it from recurring." Concerns regarding unsafe supply storage: 1. Observation on 9/6/15 beginning at 6:13 PM showed resident #57 wandered down a small	F 323		

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F 323	Continued From page 34 side hall where a mechanical lift was stored, climbed over the lift and entered an unlocked nursing supply closet, closing the door behind him/her. At 6:17 PM, the resident left the closet, carrying a toothbrush, toothpaste and a box of surgical tape. The resident climbed over the mechanical lift again, and then walked away toward his/her room. Observation of the nursing supply closet at 6:20 PM showed the closet contained supplies that included twin-bladed razors and alcohol-based instant hand sanitizer. Review of the 8/10/15 quarterly MDS assessment showed the resident had short and long term memory problems, was severely impaired, and wandered. Interview with the DON and regional RN #1 on 9/11/15 beginning at 5:50 PM confirmed it was not safe for cognitively impaired residents to access supply closets, and further confirmed nursing supply closets should be locked.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328		

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F 328	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure 1 of 3 sample residents (#30) received the proper treatment related to respiratory care. The findings were: 1. Review of the 4/12/15 admission MDS assessment showed resident #30 was admitted on 3/30/15 with diagnoses that included chronic obstructive pulmonary disease, congestive heart failure, hypertension, and anxiety. Review of the physician admission orders showed the resident was re-admitted to the facility on 5/19/15 following a hospital stay. Review of the physician orders dated 6/9/15 showed Duoneb 0.5 mg- 3 mg (2.5 mg/ 3 mL) solution every four hours as needed for shortness of breath. Review of the physician orders dated 5/20/15 showed the following order related to oxygen: "__ LPM 02 via NC [liters per minute of oxygen via nasal cannula];" however, no value was given to indicate how many liters per minute. Review of the daily skilled summary sheets dated daily from 5/23/15 to 6/6/15 showed the resident was receiving 4 liters of oxygen via nasal cannula daily. The following concerns were identified: a. Review of the situation background assessment recommendation (SBAR) communication form dated 6/14/15 showed the resident was found in his/her room by a nurse to be "blue in the face with altered LOC [level of consciousness] SOB [short of breath] with increased respirations." The resident's vital signs were taken at that time and showed his/her blood pressure was 208/124, pulse rate was 114 beats per minute, respirations were 24 breaths per	F 328	F328 Corrective Action: Resident #30 no longer resides in the facility. ID of Others: DON or designee will review the residents who have oxygen in order to ensure that the liters are clearly specified for each resident. Systemic Changes: DON or designee will review physician's orders daily for oxygen orders, Monday-Friday x 4 weeks, then weekly x 4 weeks, then, monthly x 2. Monitoring: Nursing/designee will track and trend the results of audits completed and report findings to the QAPI committee The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	10/19/15

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F 328	Continued From page 36	F 328		

minute, and oxygen saturation level was 50% on 4 liters per minute of oxygen via nasal cannula. Further review showed the resident had increased confusion, abnormal lung sounds, and slurred speech. Immediate interventions included repositioning, a nebulizer treatment with instructions for breathing out through pursed lips, and a non-rebreather mask. The note stated the resident was "rapidly improving," with a blood pressure of 185/93, pulse rate of 92, respiration rate to 22, and oxygen saturation level of 93%. Additional intervention included "Res [resident] educated on smoking cessasion (sic)."

b. Review of the nurse's note dated 6/15/15 and timed 12-6 am shift showed the resident had no concerns other than "s/he states s/he is really tired and feels like s/he slept most of the day." The note further indicated the resident received nebulizer treatments two times which the resident stated "helped [him/her] out very much." Additionally, the resident's oxygen saturation level was recorded at 94% on 3 liters of oxygen via nasal cannula. Review of the nurse's note dated 6/16/15 and timed 8:35 PM showed the resident "continues to have anxiety d/t [due to] breathing difficulties. Breathing treatments given and are effective." Further review showed the space to record the resident's oxygen saturation level was left blank. Review of the nurse's note dated 6/17/15 and timed 12:30 PM showed the resident "continues to be anxious about oxygen levels and [his/her] breathing." Further, it revealed "often times res [resident] is found out in the hallway without [his/her] O2 on." The note records the resident's oxygen saturation level was 95%.

c. Review of the respiratory care plan, last updated 3/30/15, showed the resident had difficulty breathing "at times" and shortness of breath "at times." Further review showed

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F 328	Continued From page 37 approaches included monitor vital signs and breath sounds as needed, "pulse oximetry as indicated," and "administer oxygen as ordered." Review of the interim plan of care dated 5/19/15 upon the resident's re-admission showed "oxygen as ordered" and "breath sounds as indicated" as interventions. The care plan did not address the resident's tendency to remove his/her oxygen or the anxiety related to breathing. d. Interview with RN #2 on 9/9/15 at 5:15 PM revealed the resident was often anxious about his/her breathing and complained of shortness of breath. She further confirmed the resident often removed the nasal cannula. Additionally, she confirmed there was no evidence of specific orders for liters per minute or oxygen titration range for the resident. She revealed there was no evidence the physician was contacted to clarify the order and she was unsure of how many liters per minute of oxygen the resident should have received.	F 328		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	F 371		

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F 371	Continued From page 38 facility failed to ensure proper hand hygiene techniques were followed by 1 of 2 dietary staff (cook #1) while working with food and clean equipment. The findings were: Observations of the evening meal preparation on 9/9/15 at 4:36 PM showed cook #1 failed to perform hand hygiene after coming into contact with unclean refrigerator/freezer door handles. These instances occurred at 4:43 PM, 4:47 PM, and 4:51 PM. After each occurrence the cook proceeded to work with food and handle clean dishware and equipment for the residents' evening meal. Observation of the door handles showed they were visibly soiled with debris. Interview with the dietary manager on 9/9/15 at 4:59 PM verified staff are taught to wash their hands when they become soiled, and before putting on gloves. He verified the door handles were considered unclean. According to Food Code 2013, U.S. Public Health Service, 2-301.14 When to Wash: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms... "(E) After handling soiled EQUIPMENT or UTENSILS...(H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands	F 371	F371 Corrective Action: Dining staff are currently following proper hand hygiene techniques. ID of Others: All residents could potentially be affected by this alleged deficient practice. Systemic Changes: Dietary Manager/designee will educate all dining staff on proper hand hygiene techniques on or before 10/19/15 Dietary Manager will conduct 3-5 random observations of dietary staff utilizing proper hand hygiene techniques weekly x 4 weeks, then monthly x 2 months. Monitoring: Dietary Manager/designee will track and trend the results of audits completed and report findings to the QAPI committee The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	10/19/15
F 385 SS=D	483.40(a) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of	F 385		

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F 385	Continued From page 39 each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure the care was supervised by a physician for 1 of 68 sample residents (#30). The findings were: 1. Review of the 4/12/15 admission MDS assessment showed resident #30 was admitted on 3/30/15 with diagnoses that included chronic obstructive pulmonary disease, congestive heart failure, hypertension, and anxiety. Review of the physician admission orders showed the resident was re-admitted to the facility on 5/19/15 following a hospital stay. Further review of the admission orders showed "Lasix 20 mg tab" daily, "metoprolol 50 mg tab" two times daily, and "Pravastatin 40 mg tab" daily. Review of the physician orders dated 6/9/15 showed Duoneb 0.5 mg- 3 mg (2.5 mg/ 3 mL) solution every four hours as needed for shortness of breath. The following concerns were identified: a. Review of the physician orders dated 5/20/15 showed the following order related to oxygen: "__ LPM 02 via NC [liters per minute of oxygen via nasal cannula];" however, no value was given to indicate how many liters per minute. Review of the daily skilled summary sheets dated daily from 5/23/15 to 6/6/15 showed the resident was receiving 4 liters of oxygen via nasal cannula daily. b. Review of the situation background assessment recommendation (SBAR)	F 385	F385 Corrective Action: Resident #30 no longer resides in the facility. ID of Others: The facility will review the 24 hour report for the past 30 days. Any changes in condition will be reviewed in order to ensure that the physician was notified, and that any interventions were completed, and any education needed will be conducted. Systemic Changes: DON/designee will review physician's order and 24-hour report on random shifts and unit for changes in conditions. DON/designee will conduct audit on different shifts and units by utilizing the 24-hour reports, physician's orders and PCC dashboard to identify that changes in condition are addressed with MD and any timely and appropriate interventions. DON/designee will educate nursing staff on or before 10/19/15 identifying changes of condition and follow through.	10/19/15

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F 385	Continued From page 40 communication form dated 6/14/15 showed the resident was found in his/her room by a nurse to be "blue in the face with altered LOC [level of consciousness] SOB [short of breath] with increased respirations." The resident's vital signs were taken at that time and showed his/her blood pressure was 208/124, pulse rate was 114 beats per minute, respirations were 24 breaths per minute, and oxygen saturation level was 50% on 4 liters per minute of oxygen via nasal cannula. Further review showed the resident had increased confusion, abnormal lung sounds, and slurred speech. Additionally, immediate interventions included repositioning, a nebulizer treatment with instructions for breathing out through pursed lips, and a non-rebreather mask. The note stated the resident was "rapidly improving," with a blood pressure of 185/93, pulse rate of 92, respiration rate to 22, and oxygen saturation level of 93%. Additional intervention included "Res [resident] educated on smoking cessasion [sic]." The form indicated the physician was notified on that date; however, there was no evidence the physician received the notification or provided orders related to the elevated blood pressure, abnormal lung sounds, altered level of consciousness, decreased oxygen saturation, or increased confusion. c. Review of the nurse's note dated 6/15/15 and timed 12-6 am shift showed the resident had no concerns other than "s/he states s/he is really tired and feels like s/he slept most of the day." The note further indicated the resident received nebulizer treatments two times which the resident stated "helped [him/her] out very much." Additionally, the resident's oxygen saturation level was recorded at 94% on 3 liters of oxygen via nasal cannula. Review of the nurse's note dated 6/16/15 and timed 8:35 PM showed the resident	F 385	Monitoring: Nursing/designee will track and trend the results of audits completed and report findings to the QAPI committee The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	

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F 385	Continued From page 41 "continues to have anxiety d/t [due to] breathing difficulties. Breathing treatments given and are effective." Further review showed the space to record the oxygen saturation level was left blank. Review of the nurse's note dated 6/17/15 and timed 12:30 PM showed the resident "continues to be anxious about oxygen levels and [his/her] breathing." Further, it revealed "often times res [resident] is found out in the hallway without [his/her] O2 on." The note records the resident's oxygen saturation level as 95%. Review of the nurse's note dated 6/18/15 and timed 9 PM showed the resident was "absent of vitals" and pronounced dead. No other notes or vital signs were documented for that day. d. Interview with RN #2 on 9/9/15 at 5:15 PM confirmed there was no evidence the doctor received the communication or provided orders regarding the change in condition on 6/14/15. She revealed the facility did not pursue additional assessments or increase monitoring of the resident as the oxygen saturation levels were above 90% and they "felt things were better" with the resident. She further confirmed there was no indication on the physician order form for how many liters of oxygen the resident was to receive, or parameters for oxygen titration to maintain the resident's oxygen saturation levels within a specified range. She revealed there was no evidence the physician was contacted to clarify the order and she was unsure of how many liters per minute of oxygen the resident should have received.	F 385		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 425		

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F 425	Continued From page 42 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 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 medical record review and staff interview, the facility failed to ensure adequate supervision concerning the medication administration program which impacted 4 of 68 sample residents (#11, #51, #32, #63). The findings were: 1. Review of physician orders for resident #51 showed an order dated 7/12/15, untimed, for Keflex (an anti-microbial medication) 250 mg to be given by mouth four times daily for 10 days as treatment for a urinary tract infection. Review of the resident's MAR for July 2015 showed the first dose of the medication was administered at 6 PM on 7/12/15. Further review showed only 33 of the 40 doses ordered were initialed as having been administered.	F 425	F425 Corrective Action: Resident #11 is receiving medications as ordered. Resident #51 is receiving medications as ordered. Resident #32 is receiving medications as ordered. Resident #63 is receiving medications as ordered. ID of Others: DON or designee will audit physician's orders for the past 30 days to ensure antibiotics given as ordered. If not, medication variances will be completed. DON/designee will review any residents with narcotic pain medications ordered to determine availability. Any medications that are unavailable will be ordered STAT from the pharmacy or pulled from the e-kit. Systemic Changes: DON or designee will review physician's orders daily for antibiotics to ensure they are given, and oxygen orders, Monday-	10/19/15

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F 425	Continued From page 43 2. Review of physician orders for resident #32 showed an order dated 6/18/15, timed 5:45 PM, for Keflex 500 mg to be given four times daily for 10 days as treatment for cellulitis. Review of the resident's MAR for June 2015 showed the first dose of the medication was given at 8 PM on 6/18/15. Further review showed the 8 AM and 12 PM doses that were to be administered on 6/25/15 were not initialed as having been administered; only 38 of the 40 ordered doses were initialed as having been administered. 3. Review of physician orders for resident #63 showed an order dated 5/28/1/5, timed 4:30 PM, for Keflex 500 mg to be given by mouth three times daily for 10 days as a treatment for a skin infection. Review of the resident's MARs for May and June 2015 showed only 29 of the 30 ordered doses were installed as having been administered. 4. Review of the 7/10/15 annual MDS for resident #11 showed the resident had pain frequently and received scheduled and prn (as needed) pain medication. Review of 7/29/15 care plan showed the resident had shoulder joint pain and approaches included administer pain medication, observe for signs and symptoms of pain and monitor every shift. Further review of the care plan showed the resident did not usually verbalize pain and non-verbal signs included crying and rubbing his/her arm. Review of the physician's orders showed Percocet 5 mg-325 milligrams (medication for pain) three times a day was ordered on 5/14/15. Further review also showed an order for Tylenol prn every four hours. The following concerns were identified: a. Review of the September 2015 MAR	F 425	Friday x 4 weeks, then weekly x 4 weeks, then monthly x 2. DON/designee will audit residents who have pain medications ordered, 3x/week x 4 weeks, then monthly x 3 to ensure narcotic availability and being administered as ordered. DON/designee will educate nursing staff on follow through on physician's orders and medication availability. Monitoring: Nursing/designee will track and trend the results of audits completed and report findings to the QAPI committee The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	

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F 425	Continued From page 44 showed staff did not administer the Percocet on 9/1/15, 9/2/15 and 9/3/15 because the medication was not available on those dates. b. Review of the 9/1/15 nursing notes revealed the resident was out of pain pills, cried most of the shift and was up and down in the bed throughout the night. c. Interview on 9/9/15 at 6:15 PM with the MDS coordinator revealed the medication was not available due to a problem with the communication between the physician and pharmacist. 5. Interview with RN #2 on 9/11/15 at 8:50 AM confirmed the facility should be recording and investigating a medication error every time a medication is omitted. 6. Interview with regional RN #1 on 9/11/15 at 10:35 AM confirmed the facility was not following procedures to ensure the accurate administration of all drugs to residents, as they did not have documentation to indicate medication errors were being reported and investigated for cause.	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431		

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	535025	A. BUILDING _____ B. WING _____	C 09/11/2015

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CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

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F 431	Continued From page 45 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff and pharmacist interviews, the facility failed to ensure home medications were labeled in accordance with currently accepted professional principles, for 1 of 1 sample resident reviewed for administrations of home medications (#3). The findings were: Review of the July 2015 to September 2015 MARs and physician's orders revealed scheduled medications for resident #3 included Xenazine (medication used to treat involuntary muscle movement) 25 milligrams (mg) four times a day. Interview on 9/10/15 at 10:50 AM with LPN #2	F 431	F431: Corrective Action: Resident #3 is currently receiving medications from properly stored and labeled container. ID of Others: Medication carts were audited to ensure medications were stored and labeled correctly. Any medications that were not, were discarded. Systemic Changes: DON/designee will complete random audits of the medication carts weekly x 4, and then monthly x3 to ensure that medications are stored and labeled properly. DON/designee will educate nursing staff on proper medication storage. Monitoring: Nursing/designee will track and trend the results of audits completed and report findings to the QAPI committee The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	10/19/15

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F 431	Continued From page 46 revealed the family brought the medication to the facility in pharmacy labeled pill containers. At that time the medication labels on 1 partially full and 1 empty container in the medication cart were observed with the LPN. The following concerns were identified: a. Review of the label on the empty container revealed the medication was identified as Xenazine 25 milligrams and 120 pills were dispensed on 6/15/15. b. Review of the label on the second container revealed the dispensing date was 7/21/15 and approximately 40 of the 120 pills were in the container. c. Interview with the LPN during the observation revealed the family routinely brought in containers with outdated labels. She further stated the facility did not have a system for monitoring the number of pills and the date the pills were received to ensure the medication was administered as prescribed. d. Interview with the pharmacist on 9/11/15 at 10:15 AM revealed it is important to have a monitoring system for all medication. He further stated he was available to assist the staff with this problem, but they had not reported it to him.	F 431	F498 Corrective Action: CNA #1, #2, and #3 have all completed a CNA competency checklist. ID of Others: SDC/designee will review current CNA's files to ensure that they have completed a CNA competency checklist. Systemic Changes: SDC/designee will ensure competency skills checklists are completed for current and any newly hired CNA's. Monitoring: SDC/designee will track and trend the results of audits completed and report findings to the QAPI committee The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	10/15/15
F 498 SS=E	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:	F 498		

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F 498	Continued From page 47 Based on employee file review and staff interview, the facility failed to ensure competency of skills were completed for 3 of 3 CNAs reviewed (#1,#2,#3). The findings were: Review of the employee education files for CNAs #1, #2, #3 showed each of the files contained a check list titled "Employee New Hire Orientation." This orientation consisted of several parts; however, there was no portion that was identified as an demonstration of competency skills. Interview with the staff development coordinator on 9/11/15 at 11:28 AM verified the training program was being re-organized and the competency skills checks for the aides had not been completed. He further revealed he was new to the position and there was planned education and new forms provided to cover the CNA skills including mechanical lifts, body mechanics, and gait and transfers. The start dates were as follows: a. CNA #1 started on 8/17/15. b. CNA #2 started on 7/29/15. c. CNA #3 started on 8/17/15.	F 498	F520: Corrective Action: See corrective action for: F225 F250 F253 F279 F314 F328 F371 F520 ID of Others: See identification of others for: F225 F250 F253	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment	F 520	F279 F314 F328 F371 F520 Systemic Changes: NHA/designee provided education on the QAPI process to the members of the Quality Assurance and Process Improvement (QAPI) committee at an ad hoc meeting (for the purpose of	

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F 520	Continued From page 48 and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, observation, and review of policy and procedure, the facility failed to implement an effective quality assurance performance improvement (QAPI) program to identify and correct previously identified deficiencies in a variety of areas. The findings were: Review of the 6/18/15 previous recertification survey showed deficiencies were cited for F225, F250, F253, F279, F314, F328, F371, and F520. The revisit survey on 8/14/15 put the facility back into compliance with these citations. The facility had corrected the identified deficient practice as of 7/23/15. Review of the current complaint survey findings from 9/8/15 to 9/11/15 showed these same areas were determined to be out of compliance. Interview with the facility administrator and the regional administrator on 9/11/15 at 5:45 PM revealed the QAPI program continued to collect data in these areas; however, the problems continued. The facility administrator	F 520	addressing survey issues), held on or before 10/19/15. NHA and IDT will be educated by District Clinical Nurse Consultant or designee on or before 10/19/15. When the District Team Members are in the facility, the QA/PI minutes will be reviewed for three months for effectiveness. Monitoring: NHA/designee will track and trend the results of audits completed and report findings to the QAPI committee The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	

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F 520	Continued From page 49 verified she and the management team needed to further develop the QAPI program to ensure effective interventions to correct the re-cited areas.	F 520		