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

PRINTED: 10/08/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	C 09/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS In conjunction with the recertification survey, a complaint survey was conducted by the Office of Healthcare Licensing and Surveys from 9/21/15 to 9/24/15. The survey was prompted by complaint intakes #WY00002040 and #WY00002070. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 152 SS=D	483.10(a)(3)&(4) RIGHTS EXERCISED BY REPRESENTATIVE In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf. In the case of a resident who has not been judged incompetent by the State court, any legal surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical	F 152	F152 Correction for cited residents: Resident #23 Durable Power of Attorney paperwork scanned in to resident's medical record 09/30/15. Identification of other residents: All residents are at risk to have inadequate documentation of legal representatives. Systematic Changes and Monitoring: Review and revise admission agreement to reflect presence of a durable power of attorney if applicable. Develop a process to communicate with families at overall plan of care meeting and verify DPOA if applicable. Conduct staff education related to the durable power of attorney paperwork and completion. Review and revise policy to reflect process. Outcome: 100% of resident records will have documentation of a DPOA if applicable completed upon admission, annually and upon changes in resident competence and/or legal representatives. Continuous quality improvement activities with oversight by Quality committee will be conducted. Social Services will collect data from chart audits and care plan audit monthly. Data will be aggregated and reported quarterly at long term care quality meetings with discrepancies investigated and resolved.	11/08/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Beldea | TITLE: Administrator | (X6) DATE: 10/27/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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WY Dept of Health
OCT 27 2015
Healthcare Licensing and Surveys

Over

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F 152	Continued From page 1 record review, and review of facility policies and procedures, the facility failed to ensure 1 of 21 sample residents (#23) had a legal representative to exercise the resident's rights. The findings were: 1. Review of the 7/10/15 quarterly MDS assessment showed resident #23 had diagnoses that included non-Alzheimer's dementia. Further review showed the resident's Brief Interview of Mental Status (BIMS) score was 3/15. Observation from 9/21/15-9/24/15 showed the resident resided on the secure memory care unit. Review of the resident's demographic information revealed no power of attorney (POA) designation. Interview with the DON on 9/24/15 at 1:07 PM confirmed there was no documentation for a POA in the resident's medical record. She further revealed a care conference was held in April 2015 with the resident's spouse; however, no POA paperwork was completed at that time. 2. Review of the facility policy and procedure titled "Durable Power of Attorney" updated June 2014 showed "Long Term Care (LTC) shall provide quality care while respecting Resident's rights for self-determination, including the desire to designate a durable power of attorney (DPOA)... At the first Overall Plan of Care (OPC) meeting the social services team will verify the presence and correctness of the DPOA with the family and or resident and make any necessary changes in the EMR [electronic medical record]."	F 152		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have	F 225		

11/9/15 This POC was accepted with agreed to changes at F. 253 (Handrails) between Jonni Belser, Administrator and Tony Madden, Surveyor and a DOC of 11/18/15 for 4th Tags. 11/9/15

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F 225	Continued From page 2 been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must 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 review of facility investigations, review of State survey agency logs, and staff interview,	F 225	F 225 Correction for cited residents: Report related to investigation of narcotic discrepancy and diversion submitted to WDOH State survey and certification agency 10/16/15. Clarification related to scheduled medications and medication aide administration obtained. Report of suspicious unsubstantiated results to the State board of nursing 10/27/15. Camera and badge access system on the med-dispense room installed in June 2015. Clarification of police report to reflect police statement he had nothing else to add and could not find any reason to charge any employee at Pioneer Manor or continue investigation. Identification of other residents will occur by: All residents and staff have the potential to be affected by narcotic discrepancies and diversion activities. Systematic Changes and Monitoring: Investigations related to narcotic discrepancies and diversion will be reported to WDOH State survey and certification agency By Administrator or designee Revision of narcotic count sheet to include cards received as well as actual pills. RN/LPN and Medication aide education by DON regarding narcotic counts, narcotic destruction and role definition. Daily removal of discontinued narcotics to continue to limit opportunity for diversion.	11/08/15

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F 225	Continued From page 3 the facility failed to report the misappropriation of resident property (medications) to the State survey and certification agency for 2 of 5 reportable incidents reviewed. The findings were: 1. Review of facility investigations showed an investigation was initiated due to a 6/20/15 incident involving 30 missing Oxycodone (a controlled substance) tablets. Review of State survey agency logs failed to show any report of misappropriation of resident property was made for that date. 2. Review of facility investigations showed an investigation was initiated due to an 8/12/14 incident involving 35 missing Norco (a controlled substance) tablets. Review of State survey agency logs failed to show any report of misappropriation of resident property was made for that date. 3. Interview with the DON on 9/24/15 at 11:45 AM revealed the incidents had not been reported to the State survey agency because the facility was unaware such incidents were reportable as a misappropriation of resident property.	F 225	F225 continued Outcome: 100% episodes of narcotic diversion will be reported to WDOH State survey and certification agency and Wyoming State Board of Nursing. Continuous quality improvement activities with oversight by Quality committee will be conducted. DON or designee will collect data from monthly audits. Data will be aggregated and reported quarterly at long term care quality meetings with discrepancies investigated and resolved.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	F 241		

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F 241	Continued From page 4 facility failed to promote dignity for 1 of 21 sample residents (#47) and 1 non-sample resident (#17) during random observations. The findings were: 1. Review of the 9/2/15 quarterly MDS assessment showed resident #47 rarely made him/herself understood and required the supervision of 1 staff member for eating. Review of the resident's nutrition care plan, updated on 9/2/15, showed the resident required assistance with meals and was at risk for malnutrition. Review of the resident's communication care plan, updated on 9/18/15, showed the resident had impaired communication and a hard time being understood. The following concerns were identified: a. Observation on 9/23/15 at 5:17 PM showed the resident was laying in bed. A tray table was positioned over the bed and a meal tray was placed in front of the resident. The meal appeared to have some bites taken out of it. LPN #1 attempted to get the resident to eat some of the meal. The resident shook his/her head side to side; however, the nurse continued to attempt to persuade the resident to try and eat. After attempting to get the resident to eat the food, another staff member entered the room with the resident's dinner meal. The staff member identified the previous meal tray as being the lunch meal that was left in the resident's room. b. Interview with the DON on 9/24/15 at 12:15 AM revealed meals should not be left in resident's room for more than 1 hour after the appropriate food temperature has been obtained by the dietary staff to prevent food borne illness. Further, the DON revealed it was undignified for a resident to have staff attempt to serve them cold food from a previous meal.	F 241	**F241** **Correction for cited residents:** **Resident#47** Education of staff routinely assigned to this resident will be completed to review incident and corrective actions needed to prevent future occurrences. Care plan reviewed and endorsed interventions. **Resident #17** Education of staff routinely assigned to this resident will be completed to review incident and corrective actions needed to prevent future occurrences. **Identification of other residents will occur by:** Any resident is at risk for breaches of dignity during cares. **Systematic Changes and Monitoring:** Staff education of nursing staff regarding meal tray delivery, assistance with meals including respecting resident dignity/special needs and documentation of meal intake. Rounding by DON, Nursing Director and Supervisors to assure adherence to the plan of care regarding resident dignity. Develop audit rounding tool to utilize for consistent documentation of dignity preservation and meal intake.	11/08/15

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F 241	Continued From page 5 2. Observation on 9/22/15 at 11:15 AM in the secure unit dining room showed CNA #1 and CNA #2 assisting resident #17 in a sit-to-stand lift to the bathroom. At that time the seat of the resident's pants were observed to be wet. The following concerns were identified: a. At 11:23 AM the CNAs emerged from the bathroom with the resident. At that time, the resident was observed to be wearing the same pants, and the seat of the pants continued to be visibly wet. The resident was placed in a wheelchair and wheeled to a dining room table. b. Interview at that time with CNA #2 revealed she was unaware the resident's pants were wet. Following the interview, CNA #2 and CNA #3 attempted to place the resident back in the sit-to-stand lift to change the pants, but the resident became tearful and they were unable to change the pants at that time.	F 241	F241 Cont. Outcome: 100% of rounding observations will reflect resident dignities are being performed with adherence to the plan of care. Continuous quality improvement activities with oversight by Quality committee will be conducted. DON or designee will collect data from monthly audits. Data will be aggregated and reported quarterly at long term care quality meetings with discrepancies investigated and resolved.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to provide medically-related social services to 1 of 1 sample residents (#77) with identified social service needs. The findings were: Review of the 8/25/15 quarterly MDS assessment	F 250	F250 Correction for cited residents: Resident # 77 Resident has a dental appointment 12/11/15 to evaluate and address dentition needs. Identification of other residents will occur by: All residents have the potential to be affected by altered oral condition and impaired dentition. Systematic Changes and Monitoring: Dental/Oral status is on the admission assessment. Dental/oral status will be reviewed with comprehensive assessment annually DON to conduct staff education related to notification of Social Services related to dental issues identified both present on admission and ongoing. Develop a post admission care process to assess each resident's dentition needs. Implement monthly audit of MDS to address dental concerns.	11/08/15

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F 250	Continued From page 6 showed resident #77 had a broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose). Observation on 9/24/15 at 9:10 AM showed a missing tooth in the resident's upper dentures. Interview with the resident at that time revealed his/her upper dentures were missing a tooth and were cracked, and s/he was unable to wear the lower dentures because they didn't "fit right." Interview with the social worker on 9/24/15 at 9:30 AM revealed she was unaware of the resident's broken dentures.	F 250	F250 Cont. Outcome: 95% of residents with dental issues will have action plan to address dental concerns including dental issues present on admission. Continuous quality improvement activities with oversight by Quality committee will be conducted. Social Services or designee will collect data from chart audits and care plan audit monthly. Data will be aggregated and reported quarterly at long term care quality meetings with discrepancies investigated and resolved.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure an environment that was clean and well maintained for 4 of 5 resident neighborhoods (100, 200 [secure unit], 300, 400 hallways). The findings were: 1. Observation on 9/24/15 at 8:25 AM showed the following handrails had exposed raw wood that presented an unsanitizable surface: a. The handrail outside room #304 had an area of exposed rough wood measuring 24.5 feet long. b. The handrail outside room #308 had an area of exposed rough wood measuring 30.3 feet long.	F 253		

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F 253	Continued From page 7 c. The handrail outside room #401 had an area of exposed rough wood at the corner of the handrail measuring 7 inches long. d. The handrail outside room #403 had an area of exposed rough wood measuring 24.5 feet long. e. The handrail outside room #404 had an area of exposed rough wood measuring 24.5 feet long. f. The handrail outside room #407 had an area of exposed rough wood measuring 34 inches long. g. The handrail outside room #409 had an area of exposed rough wood measuring 17 inches long. h. The handrail outside room #105 had an area of exposed rough wood at the corner of the handrail measuring 25 inches. i. The handrail outside room #107 had an area of exposed rough wood measuring 34 inches long. j. The handrail outside room #109 had an area of exposed rough wood measuring 17 inches long. 2. Observation on 9/24/15 at 8:45 AM showed the secure unit dining room had two wooden support columns with an area of missing floor linoleum 3/4 inches wide all around the base of the columns, with larger chips missing. Dirt and debris had accumulated in the gaps. The floor underneath the wall heater in the secure unit dining room had an area of missing linoleum measuring 4 inches wide and 1 inch deep, with dirt and debris accumulated in it. 3. Continued observation showed the secure unit dining room had a wall heater cover measuring 35 inches long that was loose and had partially	F 253	F 253 Corrections implemented as a result of survey: 11/08/15 1. Resident Handrail outside #304, 308, 401, 403,404.407,409,105,107,109 Work orders have been submitted for all of the above handrails identified during the survey for replacement or refinishing to permit proper cleaning and maintenance. Currently, handrails identified will be sanded to minimize any roughness. -cm 2. Missing floor linoleum area around two wooden support columns Flooring under the wall heater dining room with missing linoleum Work orders have been created for repair of the two wooden support columns and the flooring underneath the heater in the dining area in Neighborhood 2 to prevent dirt and debris accumulation. 3. Wall heater cover that was loose in the Memory support unit Work orders have been created for repair of the loose wall heater end cover on Neighborhood 2. Risk Identification: All facility areas are at risk for elements of disrepair. Systematic Changes and Monitoring: Administrator to provide Environmental rounding education for the DON, Nursing Director, Supervisory, EVS and Environmental staff to assure thorough inspections are completed and prompt work orders are submitted and completed for repair. Audits will be conducted for all completed work orders to verify accurate completion.	

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F 253	Continued From page 8 fallen off of the heating unit. 4. Interview with the maintenance director on 9/24/15 at 9:16 AM verified the handrails were rough, and presented an uncleanable surface. He further confirmed the areas in the floor in the secure unit dining room with missing linoleum were accumulating dirt and could not be cleaned adequately. Additionally, he confirmed that the loose heater cover was "not good at all" and temporarily secured it at that time.	F 253	F 253 continued Outcome: 95%of work orders are completed within 14 days with any discrepancies identified. Continuous quality improvement activities with oversight by Quality committee will be conducted. Administrator or designee will collect data from monthly audits. Data will be aggregated and reported quarterly at long term care quality meetings with discrepancies investigated and resolved.	
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 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:	F 279		

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F 279	Continued From page 9 Based on medical record review and staff interview, the facility failed to develop a comprehensive care plan for 2 of 21 sample residents (#4, #13). The findings were: 1. Review of the 9/21/15 comprehensive MDS assessment showed resident #4 had diagnoses that included dementia and generalized pain. Review of the Care Area Assessment (CAA) for psychotropic drug use showed the resident was "taking Celexa for [his/her] depressive disorder. Staff is monitoring for problems..." The CAA further showed the use of anti-depressants was added to the care plan. Review of the physician orders recapitulation for September 2015 showed the resident had orders for citalopram (Celexa - an antidepressant) 10 mg tablet daily for depression. Review of the entire care plan revealed no mention of the resident's depression or use of antidepressants. 2. Review of the 2/20/15 annual MDS assessment showed resident #13 had diagnoses that included Alzheimer's disease and depression. Review of the CAA for psychotropic drug use showed "[resident] takes a daily antidepressant for [his/her] depressive disorder. [S/he] gets monitored for adverse effects as well as mood changes and we will request MD or psych eval [evaluation] for changes. Medication will continue to (sic) per MD orders." The CAA further showed the use of antidepressants was added to the care plan. Review of the physician orders recapitulation last updated in August 2015 showed the resident had orders for fluoxetine (an antidepressant) 20 mg "every day in the evening for depression." Review of the entire care plan revealed no mention of the resident's depression or use of antidepressants.	F 279	F279 **Correction for cited residents:** **Resident #4** The mood/behavior care plan was updated to reflect statements of depression and use of antidepressants 09/28/15. **Resident #13** The mood/behavior care plan was updated to reflect statements of depression and use of antidepressants. **Identification of other residents will occur by:** All residents that have anti-depressants for depression have the potential to be affected and will have individualized CAA related care plan. **Systematic Changes and Monitoring:** Initial audit of all records to assure CAA's related to antidepressants and depression are addressed on the care plan and quarterly thereafter utilizing consistent audit tool. Electronic medical record access will be revised to permit all disciplines to document on the residents care plan. Administrator and DON to conduct staff education to all clinical disciplines who document on the care plan to assure complete documentation. Review and revise the mood behavior care plan to include medication use and indication.	11/08/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	C 09/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

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F 279	Continued From page 10 3. Interview on 9/24/15 at 10:15 AM with the DON confirmed the care plans for residents #4 and #13 did not address depression or the use of antidepressants.	F 279	F279 continued Outcome: 95% of care plans will reflect assessment of psychosocial and medication needs related to antidepressant use and depression. Continuous quality improvement activities with oversight by Quality committee will be conducted.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure care plans were revised and updated to meet individual needs for 2 of 21 sample residents (#4, #47). The findings were:	F 280	DON or designee will collect data from CAA and care plan audit monthly. Data will be aggregated and reported quarterly at long term care quality meetings with discrepancies investigated and resolved.	

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F 280	Continued From page 11 1. Review of the 9/2/15 quarterly MDS assessment showed resident #47 required extensive assistance from 2 staff members for bed mobility and personal hygiene. Further review showed the resident required total assist of 2 staff members for toilet use and was always incontinent of bowel and bladder. Continuous observation of the resident on 9/22/15 beginning at 9:11 AM showed the resident was lying in bed with his/her head elevated. A neck pillow was positioned under the resident's head and s/he was leaning to the left against the bed's side rail. The resident remained in the same position until 11:50 AM when CNA #1 and CNA #2 repositioned the resident and provided incontinence care. The following concerns were identified: a. Review of the "Altered Elimination" care plan updated on 9/18/15 showed the resident was incontinent and no timeframe was identified for the frequency of incontinence care or toileting. b. Review of the "Impaired Skin Integrity" care plan updated on 9/18/15 showed the resident was at risk for impaired skin integrity related to impaired mobility and incontinence and no timeframe was identified for the frequency of repositioning. c. Review of the "Self Care Deficit" care plan updated on 9/18/15 showed the resident was "considered bedbound" and no timeframe was identified for the frequency of toileting and repositioning. d. Interview with the DON on 9/24/15 at 12:15 PM revealed the timeframe for toileting and repositioning should be determined and documented on the resident's care plan. 1. Review of the 9/21/15 significant change MDS assessment showed resident #4 had diagnoses that included urinary tract infection and	F 280	F280 Correction for cited residents: Resident #47 Care plan updated per policy to reflect the frequency of toileting and repositioning to assure the timely delivery cares. Resident #4 The infection care plan updated to reflect the resident is no longer on MRSA precautions. Identification of other residents will occur by: All residents have the right to have individualized plans of care to meet their unique needs. Systematic changes and monitoring: Rounding by Supervisory staff to validate documentation of elimination, skin care and isolation precautions. Review and revise audit tool to ensure consistent rounding data collection. Conduct staff education to all clinical staff related to personal care documentation, care planning and infection precautions. Outcome: 95% of care plans will reflect frequency of elimination and skin care and infection precautions. Continuous quality improvement activities with oversight by Quality committee will be conducted. DON or designee will collect data from chart audit and rounding monthly. Data will be aggregated and reported quarterly at long term care quality meetings with discrepancies investigated and resolved.	11/08/15

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F 280	Continued From page 12 incontinence. Review of the infection care plan last updated 9/21/15 showed "I am MRSA [Methicillin-resistant Staphylococcus aureus] + [positive] in my urine." Review of the 9/10/15 physician order showed the resident's MRSA precautions were discontinued on that date. Interview with the DON on 9/24/15 at 10:15 AM revealed the resident no longer was on MRSA precautions and the care plan needed to be updated.	F323 F 280	Correction for cited residents: Resident #61 Care plan will be revised to reflect the potential for resident entrapment. 10/15/15 Resident #79 Care plan will be revised to reflect the potential for resident entrapment. 10/15/15 Resident #47 Care plans will be revised to reflect the potential for resident entrapment. 10/15/15	11/08/15
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 review of manufacturer's manual, the facility failed to ensure side rail devices for 3 of 3 sample residents (#47, #61, #79) with side rails were evaluated for safety. The findings were: 1. Review of the 9/11/15 quarterly MDS assessment showed resident #61 required the extensive assistance of 2 persons for bed mobility and transfers. Observation on 9/23/15 at 12:10 PM showed the resident had been served a room tray for lunch, was provided setup help, and was eating in bed. The following concerns were	F 323	Identification of other residents will occur by: All residents have the potential to be affected by safety risks related to side rail use. Systematic Changes and Monitoring: All residents identified with the need for side rails will have a side rail assessment that includes safety risks and need for padding to prevent skin pressure. Conduct monthly review of care plans of residents utilizing side rails to assure safety needs are identified. DON to conduct education related to limb entrapment assessment for side rail usage to clinical staff. Outcome: 95% of residents utilizing side rails will have care plans that will reflect side rail related safety needs. Continuous quality improvement activities with oversight by Quality committee will be conducted. DON or designee will collect data from monthly audits. Data will be aggregated and reported quarterly at long term care quality meetings with discrepancies investigated and resolved.	

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F 323	Continued From page 13 identified: a. Observation on 9/23/15 at 12:10 PM showed two full side rails were in use on the resident's bed, which was also equipped with an air mattress. The rails had gaps between the bars which were large enough to allow an arm to pass through. b. Review of the side rail evaluation dated 8/30/15 showed the resident requested the side rails for a sense of security due to a fear of rolling out of bed. The evaluation further showed the resident was able to turn side to side and move up and down in bed. However, the evaluation failed to include any individualized assessment of possible safety concerns, including the potential for limb entrapment, related to this resident's physical function or mental confusion when using the side rails. 2. Review of the 7/23/15 quarterly MDS assessment showed resident #79 had a brief interview for mental status (BIMS) score of 3 (indicating severe cognitive impairment) and diagnoses that included non-Alzheimer's dementia and anxiety disorder. Additionally, the resident required the extensive assistance of 2 persons for bed mobility. The following concerns were identified: a. Observation on 9/24/15 at 12:15 PM showed a side rail was attached to the outer upper side of the resident's bed. The device had gaps between the bars that measured 3 ½ inches. b. Review of the 4/25/15 side rail evaluation showed the side rails were "needed for the low loss air mattress." However, the evaluation failed to include any individualized assessment of possible safety concerns, including the potential for limb entrapment, related to this resident's	F 323		

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F 323	Continued From page 14 physical function or mental confusion when using the side rails. 3. Review of the 9/2/15 quarterly MDS assessment showed resident #47 was moderately cognitively impaired and had diagnoses that included hemiplegia, bed confinement, and chronic pain. The following concerns were identified: a. Observation on 9/21/15 at 3 PM showed a half side rail was attached to both sides of the resident's bed. The device was designed to have 2 gaps between the bars. The gaps measured 48 inches by 3 1/2 inches. b. Review of the resident's medical record showed a side rail evaluation was completed on 8/28/15, however, the evaluation failed to address the safety of the device use or potential for limb entrapment. Review of the care plan showed the resident used side rails for safety due to manufacturer recommendation related to the use of a low air loss matress. 4. Interview with the DON on 9/24/15 at 12:15 PM revealed the facility applied the side rails to beds that use a "low air loss" mattress related to the manufacturers recommendations. She further revealed the facility did not evaluate the side rails for safety concerns. 5. Review of the "Direct Supply Panacea Air Max Mattress" owner's manual showed on page 8 "Warnings...This product is designed to assist in prevention and treatment of pressure ulcers and may require other equipment. This may include, but is not limited to: 1. Bed rails for repositioning and fall prevention..."	F 323		
F 363	483.35(c) MENUS MEET RES NEEDS/PREP IN	F 363		

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F 363 SS=E	Continued From page 15 ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, review of diet cards, and staff interview, the facility failed to ensure the menu was followed related to portion sizes during 1 of 1 meal preparation/service observations. The findings were: Review of the lunch menu for 9/23/15 showed the main meal consisted of a pulled pork sandwich, coleslaw, baked beans and custard. The portion shown for the pulled pork was 3 ounces of meat. The coleslaw and the baked beans were both shown to be served as 1/2 cup portions (equivalent to 4 ounces). Observation of the lunch meal service on 9/23/15 from 10:50 AM to 11:50 AM showed the following portions were served: a The pulled pork was served using a #16 scoop which is equivalent to 1/4 cup or 2 ounces of the meat on the bun. b. The coleslaw was served using a #12 scoop which is equivalent to 1/3 Cup (less than 1/2 cup). c. The baked beans were served using one portion of a 2 ounce ladle. d. These portions were observed for meals served to resident #20, #35, and #37 whose diet cards showed they were to receive regular diets with regular portions.	F 363	F 363 Correction for cited residents: Resident #20 Adequate portion size will be provided to resident per care plan and diet order Resident #35 Adequate portion size will be provided to resident per care plan and diet order Resident #37 Adequate portion size will be provided to resident per care plan and diet order Identification of residents at risk: All residents are at risk of inconsistent meal portions. Systematic Changes and Monitoring: A utensil reference storage rack "Scoop It" to hold measuring scoops has been ordered on 10/09/15. Nutrition staff education regarding correct meal portions and use of appropriate measuring scoop was done on 10/14/15. Implement audit tool to ensure delivery of correct meal portion sizes. Review and revise staff competency and orientation checklist to reflect delivery of appropriate portion sizes.	11/08/15

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F 363	Continued From page 16 e. Interview with cook #1 and the AM supervisor on 9/23/15 at 11:40 AM verified the scoop sizes and ladle being used did not meet the required portion sizes as planned on the menu. The supervisor further revealed the planned menu was not followed for the other residents served the main meal that day who were to receive regular-sized portions.	F 363	Outcome: 95% of residents will receive correct meal portion sizes per their preference and care plan. Continuous quality improvement activities with oversight by Quality committee will be conducted. Dietary manager or designee will collect data from monthly audits. Data will be aggregated and reported quarterly at long term care quality meetings with discrepancies investigated and resolved	
F 431 SS=E	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 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	F 431		

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F 431	Continued From page 17 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, review of facility investigations, and staff interview, the facility failed to establish a system to manage controlled medications in sufficient detail to readily detect diversion for 1 of 1 controlled medication management systems. The findings were: 1. Review of facility investigations showed an investigation was initiated due to an 8/12/14 incident involving 35 missing Norco (a controlled substance) tablets. Further review of the investigation showed 4 cards of Norco were delivered to the facility on 7/16/14. At that time, the 4 cards were signed in to the facility by two facility employees. At some point after the cards were signed in, 1 of the cards went missing. The facility was unable to determine at what point in the system the card went missing. The diversion was not discovered until 8/12/14. 2. Review of facility investigations showed an investigation was initiated due to a 6/20/15 incident involving 30 missing Oxycodone (a controlled substance) tablets. Further review of the investigation showed the medication had been discontinued on 6/18/15, and was determined to be missing on 6/20/15. On 6/22/15, during the course of the investigation into the missing medication, additional controlled medications were discovered to be missing.	F 431	F431 **Correction for cited residents:** Develop and implement a system to manage controlled medications in sufficient detail to readily detect diversion (narcotic medication and dispensing system reconciliation) per shift **Risk Identification:** All patient care areas administering narcotic medications are at risk for events of drug diversion. **Systematic Changes and Monitoring:** Implement audit tool to identify in real time any narcotic discrepancies on a shift basis. Ongoing surveillance will occur and any narcotic count discrepancies will be reported promptly utilizing risk management system and an investigation completed. Proper reporting will be completed based on policy. RN/LPN and Medication aide education by DON regarding narcotic counts, narcotic destruction and role definition. **Outcome:** 100% Narcotic discrepancies will be thoroughly investigated and reported per policy. Continuous quality improvement activities with oversight by Quality committee will be conducted. All events will be monitored through the risk management system for the organizations. Administrator, DON or designee will collect data from monthly audits. Data will be aggregated and reported quarterly at long term care quality meetings with discrepancies investigated and resolved.	11/08/15

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F 431	Continued From page 18 3. Observation and review of the controlled medication management systems with the DON on 9/24/15 beginning at 11:45 AM showed the facility did not have a system in place to track the chain of custody of controlled medications from the point they entered the facility to the point they were either completely dispensed or destroyed. Specifically, once the controlled medications were placed into the locked drawer in the medication carts, the facility did not have a mechanism in place to detect diversion from the drawer. 3. Interview with the DON on 9/24/15 at 11:45 AM revealed both of the facility's recent diversion investigations had occurred after controlled medications were removed from the medication carts without authorization, and confirmed the facility did not have a system for tracking controlled medications as they were placed into or removed from the locked drawer in the medication carts.	F 431		

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