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

PRINTED: 10/22/2015
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
	535040	A. BUILDING _____ B. WING _____	10/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys at Douglas Care Center on 10/5/15 - 10/8/15. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set RD- Registered Dietitian	F 000	F280 1. The facility will ensure that a comprehensive care plan will be developed within 7 days after the completion of the comprehensive assessments. 1. Resident #4 will be repositioned every two hours and/or PRN while sitting in Geri chair. a. All residents that are at risk for pressure ulcers will be identified via	
F 280 SS=E	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	F 280	the Braden scale that is done quarterly or at a significant change. Those residents that are at high risk will be put on a two hour reposition program and will be care planned as such. b. All staff will be educated at an all nursing department meeting that will include, nurses and CNA's on the different types of repositioning according to where resident is (bed, Geri chair, wc, recliner etc....). c. CNA's that were on that particular shift have been counseled accordingly.	

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

Kelli Dodge | NHA | 10/24/15

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.

RECEIVED
WY Dept of Health

Changes made per phone call with Kelli Hoffe, NHA

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: GXXC11 Facility ID: WY0018 If continuation sheet Page 1 of 19

OCT 29 2015 VA 11/18/15 C Mich - POC accepted.

Healthcare Licensing and Surveys

Janeen Cahill RN

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F 280	Continued From page 1 by: Based on observation, medical record review, staff interview, and review of diet cards, the facility failed to ensure the care plan was updated for 4 of 12 sample residents (#3, #4, #44, #45). The findings were: 1. Review of the 11/9/14 significant change and the 8/12/15 quarterly MDS assessments showed resident #4 was at risk for pressure ulcers and was on a turning/repositioning program. Observation on 10/6/15 from 9 AM until 1:55 PM (4 hours 55 minutes) revealed the resident was in a wheeled recliner (gerichair). During the observation, the resident was not repositioned. Review of the care plan for pressure ulcer prevention (problem start date 10/15/14) showed staff were instructed to turn and reposition the resident while in bed; however, repositioning while in the chair was not addressed. During an interview on 10/8/15 at 8:30 AM the MDS coordinator and the DON confirmed the care plan did not address repositioning in the chair. The DON stated the expectation was for repositioning every two hours. 2. Review of the 9/11/15 quarterly MDS assessment revealed resident #3 was at risk for pressure ulcers and was incontinent of bowel. The following concerns were identified: a. Observation on 10/5/15 at 4:35 PM revealed the resident was in bed on an air mattress. Review of the care plan (last updated 9/25/15) showed the air mattress was not addressed. b. Continuous observation on 10/6/15 from 8 AM until 5:44 PM (9 hours 44 minutes) showed the resident was not checked for bowel incontinence. At 5:44 PM the resident was	F 280	2. Resident #3 will have his air mattress care planned as well as refusals of cushion for wheel chair. There will also be a care plan and interventions put in place for his bowel incontinence. a. All residents who have air mattress(s) and wheel chair and recliner cushions will have care plans done to address preventative skin break down interventions. b. Staff will be educated on resident #3 and all residents when they are put on a bowel program. 3. Resident #44 will have double desserts at lunch and dinner. a. Resident #44 will have it care planed that resident is to receive two desserts at lunch and dinner. b. All residents who are at risk or have had a weight loss will have the appropriate care plan addressing those specific to the resident. c. The dietary staff and nursing staff will be educated on any changes made after our weekly weight and skin. Then any other above listed staff will be caught at shifts are rotating in and out.	

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F 280	Continued From page 2 transferred to bed by CNA #3 and the restorative coordinator. The resident was incontinent of bowel and the skin was observed to be excoriated. Review of the care plan showed interventions for bowel incontinence were not included. c. Observation on 10/6/15 from 8 AM until 12 noon (4 hours) showed the resident was in bed on an air mattress. During that time, the resident was not repositioned or encouraged to reposition. On 10/6/15 from 12:05 PM until 5:44 PM (5 hours 39 minutes) the resident was observed in a wheelchair with no cushion. During that time, the resident was not repositioned or encouraged to reposition/off-load. Review of the care plan showed repositioning and a cushion for the wheelchair were not addressed. d. During an interview on 10/8/15 at 8:30 AM the MDS coordinator and the DON confirmed the air mattress, bowel incontinence, repositioning and a cushion for the wheelchair were not addressed in the care plan. The DON stated the expectation was for the resident to receive incontinence care about every two hours unless s/he refused. She further stated the resident should be repositioned or off-loaded about every two hours unless s/he refused. She stated the resident had refused wheelchair cushions in the past, but confirmed the care plan did not address that refusal, or include alternatives. 3. Review of the quarterly MDS assessment, dated 8/8/15, for resident #44 showed one of the listed diagnoses included non-Alzheimer's dementia. Review of the care plan, updated on 5/13/15, showed the resident was at risk for malnutrition due to having no natural teeth or dentures. The following concerns were noted: a. Interview with the RD on 10/7/15 at 10:40	F 280	d. Our weekly weight and skin that is held with RD and IDT will address any skin and weight issues at that time and care plan at that time accordingly. 4. Resident #45 will have weight loss concerns addressed in care plan and any interventions put in place to maintain weight will be care planned including cueing/encouragement. a. The dietary staff and nursing staff will be educated on any changes made after our weekly weight and skin. Then any other above listed staff will be caught at shifts are rotating in and out. b. Our weekly weight and skin that is held with RD and IDT will address any skin and weight issues at that time and care plan at that time accordingly. 5. All residents who are incontinent of bowel and bladder; all resident who have had or expected weight loss will have monthly audits done that there care plans are addressing such and are being implemented. This will be done by DON or designee and brought to QAPI on a monthly basis until resolved.	11/2/15

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F 280	Continued From page 3 AM verified that the resident was at risk for weight loss and also revealed the resident was supposed to receive double desserts at meals as an intervention. b. Observation of the resident on 10/7/15 at 12:03 PM showed that the resident received only one bowl of pudding for dessert at lunch. Further observation showed that, in contrast, a few other residents in the dining room received two bowls of pudding at the lunch meal. c. Review of the resident's diet card on 10/8/15 at 11:05 AM indicated that double desserts were listed for both lunch and dinner. However, review of the approaches to prevent malnutrition listed on the resident's care plan, updated on 8/12/15, did not indicate the resident was to receive double desserts as an intervention. 4. Review of the quarterly MDS assessment, dated 7/14/15 for resident #45 showed diagnoses that included non-Alzheimer's dementia, Anxiety Disorder, Manic Depression (bipolar disorder) and Schizophrenia. Review of the resident's nutrition assessment, dated 7/14/15, showed that the resident had a history of weight loss, was at risk of ongoing weight loss, and indicated the resident was supposed to be cued by staff to eat at meal times. The following concerns were noted: a. Review of the resident's care plan, updated on 8/19/15, showed that the resident "love[d] ice cream and will eat it anytime" and that the resident was to have ice cream served at meals. However, the care plan did not indicate that the resident had any issues with weight loss or any indication that the ice cream was a planned intervention to prevent further weight loss. Further review showed that the care plan did not indicate	F 280		

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F 280	Continued From page 4 at which meals ice cream was supposed to be served. Finally, the care plan did not show that the resident was supposed to be cued by staff and provided encouragement to eat at mealtimes. b. Observation of the resident on 10/6/15 at 5:15 PM showed the resident was seated at the assisted eating table and ate just a few bites of the meal, leaving at least 75% of the meal on the plate. The resident did receive some encouragement from staff to take a few more bites of his/her food. Also, by observation, the resident received a meal supplement shake with dinner, but did not receive any ice cream. c. Interview with the RD on 10/7/15 at 10:40 AM revealed the resident had a history of weight loss and should be receiving encouragement and should be getting cued to eat by staff at meal times, as well as served ice cream at lunch and dinner to prevent further weight loss. d. Interview with the DON on 10/8/15 at 9 AM verified that the resident's care plan should be updated to reflect the need for being cued by staff at meal times, as well as the purpose for the ice cream, and which meals the ice cream should be offered.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure	F 282		

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F 282	Continued From page 5 services were provided in accordance with each resident's written plan of care for 2 of 12 residents (#4, #44.) The findings were: 1. Review of the 8/12/15 quarterly MDS assessment revealed resident #4 was incontinent of bladder and was on a toileting program. Review of the urinary incontinence care plan (problem start date 5/20/15) revealed staff were instructed to "check and change regularly." However, observation on 10/6/15 revealed the resident went from 9 AM until 1:55 PM (4 hours 55 minutes) without being checked for incontinence. When the resident was checked for incontinence at 1:55 PM by CNA #1 and CNA #2 the resident was saturated with urine. During an interview on 10/8/15 at 8:30 AM the DON stated the resident should be checked for incontinence regularly, which she defined as every two hours. 2. Review of the MDS assessment dated 8/8/15 for resident #44 showed one of the listed diagnoses included non-Alzheimer's dementia. Review of the care plan, updated on 5/13/15, showed that the resident was at risk for malnutrition due to having no natural teeth and no dentures. The care plan also stated, "Resident needs cueing to eat at meals." The following concerns were noted: a. Observation on 10/6/15 at 5:15 PM showed the resident sat at a table all alone. The resident took only a few bites of the meal and ate one bowl of the apple crisp dessert. At no point during the meal did staff come over to cue the resident to eat more. At 5:29 PM the resident left the dining room, leaving an estimated 85% of the meal on the plate. b. Observation on 10/7/15 at 11:55 AM showed the resident in the dining room seated	F 282	**F282** 1. The facility will ensure that services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. 1. Resident #4 will have residents toileting care plan followed which states resident will be checked every two hours for incontinence. a. All residents who are on a toileting program will be checked or taken to the restroom every two hours. a. CNA #1 and CNA#2 both have been counseled and educated on resident #4 and all residents who are on a toileting program. b. All nursing staff will be educated on residents who are on toileting programs and the expectations of that program at the 11/2/15 nursing meeting that included nurses and CNA's.	

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F 282	Continued From page 6 next to two other residents. The resident received a piece of bread, a plate of meat with sides of beets and lima beans, and 1 bowl of pudding. The resident ate all of the pudding and attempted to eat the meat. However, several of the times that the resident took a bite, s/he chewed on the meat and then spit it back onto the plate. The resident did not attempt to eat the beans or beets. At 12:45 PM when staff came to take the resident's tray away, an estimated 80% of the meal remained on the plate. At no point during the meal did any staff members come over to encourage or cue the resident to eat more. c. Interview with the RD on 10/7/15 at 10:40 AM verified that the resident should have been cued by staff during the meal.	F 282	2. Resident #44 will be cued during meal times and moved to the asset table. a. All residents will have their updated care plans added to our nursing staff's widgets/dashboard. The widgets/dashboard will also show residents who have specific needs such as a toileting program or cuing at meals, etc... This will be put as a task so that nursing staff has to clear the dash board to acknowledge the information given. 3. DON or designee will be able to print out reports from widgets/dashboard of nursing staff acknowledging residents updated care plans and specific needs. The audit will be done on a monthly basis and taken to QAPI until resolved. There will also be periodic audits done of residents who have care plans due for the week to ensure that the plan/interventions are being done or that they are effective and successful for the resident. This will also be brought to monthly QAPI to see efficacy and it will be conducted by the care plan IDT.	11/2/15
F 309 SS=D	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 provide care to promote continence for 1 of 4 sample residents (#3) who were incontinent of bowel. The findings were: Review of the 9/11/15 quarterly MDS assessment showed resident #3 was incontinent of bowel.	F 309		

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F 309	Continued From page 7 Review of the 9/10/15 bowel and bladder assessment revealed the resident was frequently incontinent of bowel and was non-compliant with getting up to the toilet and refused the bed pan. Review of the care plan (updated 9/25/15) showed bowel incontinence was not addressed. Continuous observation on 10/8/15 from 8 AM until 5:44 PM (9 hours 44 minutes) showed the resident was not checked for bowel incontinence. At 5:44 PM the resident was transferred to bed by CNA #3 and the restorative coordinator. The resident was incontinent of bowel and the skin was observed to be excoriated. During an interview on 10/8/15 at 8:30 AM the MDS coordinator and the DON confirmed bowel incontinence was not addressed in the care plan. The DON stated the expectation was for the resident to receive incontinence care about every two hours unless s/he refused.	F 309	F309 1. The facility will ensure that each resident receives and the facility will provide the necessary care and services to attain or maintain the highest practical physical, mental and psychosocial well-being, in accordance with eh comprehensive assessment and plan of care. 1. There will be a care plan and interventions put in place for residents bowel incontinence. incl during ADL #3 2. All residents will have a care plan and interventions put in place when they are incontinent of urine and bowel. 3. All nursing staff will be educated on residents who are on toileting programs and the expectations of that program at the 11/2/15 nursing meeting that included nurses and CNA's. 4. All residents will have their updated care plans added to our nursing staff's widgets/dashboard. The widgets/dashboard will also show residents who have specific needs such as a toileting program or cuing at meals, etc... This will be put as a task so that nursing staff has to clear the dash board to acknowledge the information given.	
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 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 medical record review, observation, review of policies and procedures, and resident, family and staff interviews, the facility failed to	F 314		

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F 314	Continued From page 8 provide care to prevent pressure ulcers for 2 of 6 sample residents (#3, #4) who were at risk for the development of pressure ulcers. The findings were: 1. Review of the 9/11/15 quarterly MDS assessment and 9/10/15 Braden Scale revealed resident #3 was at risk for the development of pressure ulcers. The following concerns were identified: a. Observation on 10/6/15 from 8 AM until 12 noon (4 hours) showed the resident was in bed on an air mattress. During that time, the resident was not repositioned or encouraged to reposition. On 10/6/15 from 12:05 PM until 5:44 PM (5 hours 39 minutes) the resident was observed in a wheelchair with no cushion. During that time, the resident was not repositioned or encouraged to reposition/off-load. At 12:46 PM, during an interview, the resident stated his/her bottom got sore sometimes from sitting in the wheelchair. The resident also stated staff did not position him/her on the side when in bed. At 5:44 PM the resident was transferred to bed by CNA #3 and the restorative coordinator. Observation at that time and again on 10/7/15 at 4:50 PM showed the resident had 3 discolored areas to the right buttock and one area to the upper left leg; all areas were blanchable. b. Review of a signed statement provided by the facility dated 10/7/15 by the wound care certified (WCC) staff person revealed she felt the areas were likely caused from "tightness from the wheelchair" because the resident had been spending increased time in the wheelchair. Review of another signed statement by certified occupational therapy assistant (COTA) #1 dated 10/7/15 showed she evaluated the resident's wheelchair on 10/7/15 and found that it was too	F 314	F309 5. DON or designee will be able to print out reports from widgets/dashboard of nursing staff acknowledging residents updated care plans and specific needs. The audit will be done on a monthly basis and taken to QAPI until resolved. There will also be periodic audits done of residents who have care plans due for the week to ensure that the plan/interventions are being done or that they are effective and successful for the resident. This will also be brought to monthly QAPI to see efficacy and it will be conducted by the care plan IDT.	11/2/15

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F 314	Continued From page 9 small. She further documented that she replaced the resident's wheelchair with another one with a cushion and that the resident "agreed it would be a good idea and seemed to be really excited." During an interview on 10/8/15 at 9:36 AM the WCC staff person stated she thought the areas on the buttock looked more like deep tissue injuries and felt that the wheelchair was definitely a factor. c. Review of the care plan showed repositioning and a cushion for the wheelchair were not addressed. d. During an interview on 10/8/15 at 8:30 AM the MDS coordinator and the DON confirmed repositioning and a cushion for the wheelchair were not addressed in the care plan. The DON stated the resident should be repositioned or off-loaded about every two hours unless s/he refused. She stated the resident had refused wheelchair cushions in the past, but confirmed the care plan did not address that refusal, or include alternatives. 2. Review of the 11/9/14 significant change and the 8/12/15 quarterly MDS assessments showed resident #4 was at risk for pressure ulcers and was on a turning/repositioning program. Review of the 8/10/15 Braden Scale revealed the resident was at high risk for the development of pressure ulcers. Observation on 10/6/15 from 9 AM until 1:55 PM (4 hours 55 minutes) revealed the resident was in a wheeled recliner (gerichair). During the observation, the resident was not repositioned. During an interview on 10/6/15 at 3 PM a family member stated the resident was placed in the recliner in the morning, and was left in it until after lunch. Review of the care plan for pressure ulcer prevention (problem start date 10/15/14) showed staff were instructed to turn	F 314	F314 1. The facility will ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. a. Resident #3 will be encouraged to off load and/or reposition every two hours whether resident is in his wheel chair or bed. b. Resident #3 now has a wider wheel chair that fits his body habitus better. c. Resident #3 will have his reposition and refusal of it at times care planned. Resident will also have the refusal of a cushion for his wheel chair care planned. As the resident agreed to a cushion for his wheel chair and 24 hours later demanded it out. 2. Resident #4 will be repositioned every two hours and/or PRN while sitting in Geri chair.	

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(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 314	Continued From page 10 and reposition the resident while in bed; however, repositioning while in the chair was not addressed. During an interview on 10/8/15 at 8:30 AM the MDS coordinator and the DON confirmed the care plan did not address repositioning in the chair. The DON stated the expectation was for repositioning every two hours. 3. Review of the facility's policy "Repositioning; Level II" (1/22/15) showed "...Residents who are in bed should be on at least an every two hour (q2 hour) repositioning schedule...Residents who are in a chair should be on an every one hour (q1 hour) repositioning schedule...If the resident refuses care, an evaluation of the basis for refusal, and the identification and evaluation of potential alternatives is indicated."	F 314	F314 d. All residents who have been determined to be at risk for development of pressure ulcers determined by the Braden scale will have interventions put in place and care planned. Our weekly weight and skin that is held with RD and IDT will address any skin issues at that time and care plan at that time accordingly e. nursing staff will be educated on any changes made after our weekly weight and skin. Then any other above listed staff will be caught at shifts are rotating in and out.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and family interview, the facility failed to provide care to promote continence and keep the resident as dry as possible for 1 of 7 sample	F 315	3. All residents who have been determined to be at risk for development of pressure ulcers determined by the Braden scale will have monthly audits done that there care plans are addressing such and are being implemented. This will be done by DON or designee and brought to QAPI on a monthly basis until resolved.	11/2/15

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	535040	A. BUILDING _____ B. WING _____	10/08/2015

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F 315	Continued From page 11 residents (#4) who were incontinent of bladder. The findings were: Review of the 8/12/15 quarterly MDS assessment revealed resident #4 was incontinent of bladder and was on a toileting program. Review of the urinary incontinence care plan (problem start date 5/20/15) revealed staff were instructed to "check and change regularly." However, observation on 10/6/15 revealed the resident was seated in a wheeled recliner (gerichair) and went from 9 AM until 1:55 PM (4 hours 55 minutes) without being checked for incontinence. When the resident was checked for incontinence at 1:55 PM by CNA #1 and CNA #2 the resident was saturated with urine. An interview with CNA #1 on 10/6/15 at 2:10 PM revealed the resident should be checked and changed about every two hours, but it was not done that day because care with other residents took longer than usual. During an interview on 10/8/15 at 8:30 AM the DON stated the resident should be checked for incontinence regularly, which she defined as every two hours. During an interview on 10/6/15 at 3 PM a family member stated s/he did not believe the resident received adequate incontinence care. The family member stated the resident often smelled of urine.	F 315	F315 1. The facility will ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. 1. . Resident #4 will have residents toileting care plan followed which states resident will be checked every two hours for incontinence. a. All residents who are on a toileting program will be checked or taken to the restroom every two hours. b. CNA #1 and CNA#2 both have been counseled and educated on resident #4 and all residents who are on a toileting program.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	c. All nursing staff will be educated on residents who are on toileting programs and the expectations of that program at the 11/2/15 nursing meeting that included nurses and CNA's.	

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F 323	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and policy and procedure review, the facility failed to ensure positioning devices were assessed for safety for 3 of 3 sample residents (#3, #20, #23) who used positioning devices. The findings were: 1. Review of the 7/7/15 quarterly MDS assessment showed resident #20 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 6 out 15, and had diagnoses that included non-Alzheimer's dementia and cerebral vascular accident. Medical record review showed the resident had a history of falls and impaired memory. Observation on 10/6/15 at 1:13 PM showed the resident had a positioning device to the open side of the bed and the other side was against the wall. The device was designed to have 3 gaps that each measured 4 inches by 6 1/2 inches. The following concerns were identified: a. Observation on 10/6/15 at 3:59 PM showed the resident was laying in bed with his/her eyes closed and the resident's right arm was through the top hole of the positioning device. b. Medical record review showed that a safety assessment was not completed for the positioning device and the potential for limb entrapment was not identified. 2. Review of the 9/17/15 quarterly MDS assessment showed resident #23 was severely cognitively impaired with a BIMS score of 3 out 15, and had diagnoses that included frontal lobe	F 323	F315 d. All residents will have their updated care plans added to our nursing staff's widgets/dashboard. The widgets/dashboard will also show residents who have specific needs such as a toileting program or cuing at meals, etc... This will be put as a task so that nursing staff has to clear the dash board to acknowledge the information given. 3. DON or designee will be able to print out reports from widgets/dashboard of nursing staff acknowledging residents updated care plans and specific needs. The audit will be done on a monthly basis and taken to QAPI until resolved. There will also be periodic audits done of residents who have care plans due for the week to ensure that the plan/interventions are being done or that they are effective and successful for the resident. This will also be brought to monthly QAPI to see efficacy and it will be conducted by the care plan IDT.	11/2/15

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F 323	Continued From page 13 disturbance and traumatic brain injury. Medical record review showed the resident had a history of falls and impaired decision making. Observation on 10/6/15 at 1:11 PM showed the resident had a positioning device to the open side of the bed and the other side was against the wall. The device was designed to have 3 gaps that measured 7 inches by 4 inches at the top gap, 3 1/2 inches by 4 inches at the middle gap, and 5 inches by 3 inches at the lower gap. The following concerns were identified: a. Observation on 10/6/15 at 3:57 PM showed the resident was laying in bed and the resident's right hand was through the top hole of the positioning device. b. Medical record review showed that a safety assessment was not completed for the positioning device and the potential for limb entrapment was not identified. 3. Review of the care plan (edited 9/16/15) showed resident #3 used "assist bars" on his/her bed to help with bed mobility. Review of the 9/11/15 quarterly MDS assessment showed the resident required extensive assist of two for bed mobility and was severely cognitively impaired (scored a 5 out of 15 on the BIMS). Observation on 10/8/15 at 8:22 AM showed the resident had a positioning device on each side of the bed. The device was designed to have 3 gaps that measured 7 inches by 4 inches at the top gap, 3 1/2 inches by 4 inches at the middle gap, and 5 inches by 3 inches at the lower gap. Review of the medical record showed no evidence the facility had assessed the positioning devices for safety. 4. Review of the facility policy titled "Positioning Bars" dated 4/24/15 showed the facility failed to	F 323	F323 1. The facility will ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 1. Resident #20 will have a safety assessment completed for the position device and the potential for limb entrapments will be done. The positioning bars will also have cloth covers placed over them for safety. 2. Resident #23 will have a safety assessment completed for the position device and the potential for limb entrapments will be done. The positioning bars will also have cloth covers placed over them for safety. 3. Resident #3 will have a safety assessment completed for the position device and the potential for limb entrapments will be done. The positioning bars will also have cloth covers placed over them for safety. 4. Facility will revise Positioning Bars policy dated 4/24/15 to ad safety assess and potential for limb entrapments as well as cloth protectors over positioning bars for safety.	

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F 323	Continued From page 14 address safety or limb entrapment. 5. Interview with the DON on 10/7/15 at 2:20 PM revealed the facility did not complete safety assessments on the positioning devices; however, she confirmed the positioning device could result in injury and/or limb entrapment.	F 323	F323 5. All residents who are currently using the positioning devices will have a complete safety assessment done along with cloth protectors. As staff, family and residents request positioning devices a complete safety assessment will be done before they are attached to the bed(s). If it is determined that they are safe for the resident they will have cloth protectors placed over them. 6. DON or designee will do monthly audits of current and new residents who have positon devices that a safety assessment was done and that cloth protectors are placed. This will be done monthly and brought to QAPI until resolved.	11/2/15
F 325 SS=D	483.25(l) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure acceptable parameters of nutritional status were maintained and nutritional interventions were implemented for 2 of 4 sample residents (#44, #45) with weight loss or a history of weight loss. The findings were: 1. Review of the quarterly MDS assessment, dated 8/8/15, for resident #44 showed one of the listed diagnoses included non-Alzheimer's dementia. Review of the resident's care plan, updated 5/13/15, showed that the resident was at	F 325		

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F 325	Continued From page 15 risk for malnutrition due to having no natural teeth or dentures. The care plan also stated, "Resident needs cueing to eat at meals." The following concerns were noted: a. Observation on 10/6/15 at 5:15 PM showed the resident was sitting at a table by himself/herself. The resident ate only a few bites of the food on his/her plate and one bowl of the apple crisp dessert. At no point during the meal did staff come over to cue the resident to eat more. At 5:29 PM the resident stood up and ambulated out of the dining room using a front-wheel walker. The resident left an estimated 85% of the meal on his/her plate. b. Review of the resident's meal intakes recorded showed that on 10/5/15, the resident consumed "1-25%" of his her breakfast, "26-50%" of his/her lunch and "26-50%" of his her dinner. On 10/6/15 the resident consumed "1-25%" of his/her breakfast and "26-50%" of his/her dinner. c. Observation on 10/7/15 at 11:55 AM showed the resident in the dining room seated next to two other residents. The resident received 1 bowl of pudding for dessert, a piece of bread and a plate of beets, lima beans and meat. The resident ate all of the pudding and used his/her spoon to scrape the bowl clean. The resident also attempted to eat the meat on the plate; however, of the several times the resident took a bite of meat, s/he chewed on it and then spit it back on the plate. The resident did not attempt to eat the lima beans or beets. At 12:45 PM when staff came to remove the resident's tray, an estimated 80% of the meal remained on the plate. The resident was not cued by staff members or provided encouragement to eat more at any point during the meal. Further review of the resident's diet card on 10/8/15 at 11:05 AM revealed the resident was supposed to receive double	F 325	F325 1. The facility will ensure that a resident 1-maintains acceptable parameters of nutritional status, such as body weight and protein levels unless the resident's clinical condition demonstrates that this is not possible; and 2-receives a therapeutic diet when there is a nutritional problem. 1. Resident #44 will have it care planed that resident is to receive two desserts at lunch and dinner; she will also be moved to the assist table. a. Resident #44 will be re-assessed to determine whether or not resident needs dentures. 2. Resident #45 will have weight loss concerns addressed in care plan and any interventions put in place to maintain weight will be care planned including cueing/encouragement as well as desserts. a. The dietary staff and nursing staff will be educated on any changes made after our weekly weight and skin. Then any other above listed staff will be caught at shifts are rotating in and out.	

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F 325	Continued From page 16 desserts at both lunch and dinner. d. Review of the resident's nutrition assessment dated 8/8/15 showed the resident "has dentures or removable bridge" which contrasted with the information on the care plan that stated the resident is at risk of malnutrition due to having no teeth or dentures. Interview with the RD on 10/7/15 at 11:35 AM confirmed that the nutrition assessment was incorrect and the resident did not actually have dentures. The RD revealed he had thought the resident had dentures; however, he believed the resident was able to eat a regular meal without dentures. The RD verified that the resident was at risk for weight loss and also revealed the resident was supposed to receive double desserts at meals, as well as cueing and encouragement from staff. e. Interview with the DON on 10/8/15 at 9 AM revealed that the resident had lost his/her dentures at some point and the facility had not replaced them because the facility staff believed the resident was able to eat without them and the resident's family was in agreement. However, the DON agreed that the resident should be re-assessed to determine whether or not he/she needed dentures. The DON verified that staff should have cued the resident to eat at the meal as indicated in the care plan, and also agreed the care plan should be updated to indicate the resident was to receive double desserts at meals. f. Further review of the medical record showed that on 8/5/15, the resident weighed 120.4 pounds. When weighed again on 9/18/15, the resident's weight had decreased to 117.2 pounds. 2. Review of the quarterly MDS assessment, dated 7/14/15, for resident #45 showed diagnoses that included non-Alzheimer's	F 325	b. Our weekly weight and skin that is held with RD and IDT will address any skin and weight issues at that time and care plan at that time accordingly. 3. All residents who have had or expected weight loss will have monthly audits done that there care plans are addressing such and are being implemented. This will be done by DON or designee and brought to QAPI on a monthly basis until resolved. 4. DCC does not follow therapeutic diets such as heart healthy or ADA diets as it has been found they are of no benefit to the elderly. We do use fortify and other supplements such as boost and med pass for our residents who have poor nutritional risk. For our residents who are off of our secure unit we provide our residents snacks three times a day and have our café open to them 24 hours a day. For our residents there are snacks provided three times a day as well as a fridge that is stocked with snacks that are accessible to the residents 24 hours a day.	11/2/15

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F 325	Continued From page 17 dementia, Anxiety Disorder, Manic Depression (bipolar disorder) and Schizophrenia. Review of the resident's nutrition assessment, dated 7/14/15 showed that the resident had a history of weight loss, was at risk of ongoing weight loss and indicated the resident was supposed to be cued by staff and encouraged to eat at meal times. The following concerns were identified: a. Review of the resident's care plan, updated on 8/19/15, showed that the resident loved ice cream and revealed that the resident was to have ice cream served at meals. However, the care plan did not indicate that the resident had any issues with weight loss, and did not indicate the ice cream was an intervention to prevent further weight loss. Further review showed that the care plan did not indicate at which meals ice cream was supposed to be served. In contrast, review of the diet card on 10/7/15 at 11:35 AM revealed the resident was supposed to receive two ice creams with lunch and dinner. Finally, the care plan also did not show that the resident was supposed to be encouraged and cued by staff to eat at meal times. b. Observation of the resident on 10/6/15 at 5:15 PM showed the resident was seated at the assisted eating table and ate just a few bites of the meal, leaving 75% of the meal on the plate. The resident did receive some encouragement from staff to take a few more bites of the food. Also, by observation, the resident received a meal supplement shake with dinner, but did not receive any ice cream. c. Interview with the RD on 10/7/15 at 10:40 AM verified that the resident had a history of weight loss, was at risk for future weight loss, and should be encouraged by staff and cued to eat at meal times. The RD also verified that the ice cream was an intervention put in place after the	F 325		

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F 325	Continued From page 18 resident had more than a 5% weight loss within 30 days in August, 2015, and that the resident should be served ice cream at both lunch and dinner to prevent further weight loss. d. Interview with the DON on 10/8/15 at 9 AM revealed that the staff was aware the resident had been eating less food lately and that this could be related to a manic stage in his/her bipolar disorder. However, the DON was unaware the care plan did not indicate ice cream should be served at lunch and dinner as an intervention against further weight loss and also was unaware that the care plan did not indicate the resident needed to be cued by the staff during meals. The DON agreed that the resident's care plan should be updated to reflect the need for the resident to be cued and receive encouragement from staff at meal times, as well updated to reflect the purpose for the ice cream, and which meals the ice cream should be offered.	F 325		