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Healthcare Licensing and Surveys

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

PRINTED: 11/20/2015
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
	535031	A. BUILDING _____ B. WING _____	C 11/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER REHABILITATON AND WELLNESS	1002 FOREST DRIVE RIVERTON, WY 82501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 11/2/15 through 11/5/15. Also reviewed in the course of this survey was complaint intake WY000002096. The following common abbreviations are used throughout this document: ADLs: Activities of Daily Living CAA: Care Area Assessment CNA: Certified Nurse Aide DON: Director of Nursing LPN: Licensed Practical Nurse MDS: Minimum Data Set NHA: Nursing Home Administrator Less commonly used abbreviations will be annotated in each deficiency.	F 000	This Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws.	
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 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	F 225	F 225 The facility shall provide documentation of abuse registry verification for C NA #1. Identification of Others: Business Office Manager and/or designee shall conduct an inspection of personnel files requiring verification from the abuse registry to validate documentation is included in the file. Systemic Changes: Executive Director and/or designee shall provide education to hiring managers and Staff Development Coordinator relating to abuse registry verification requirements. Monitoring: Business Office Manager and/or designee shall audit files for new hires who require abuse registry verification to validate verification is documented. Audits shall be completed for all new hires. Audits	12/14/15

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

ED — Resubmitted — 12-9-15

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.

12/11/15 - 11:21 Spoke c Joann Aldrich ED, Plan of Correction accepted.

Tim

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F 225	Continued From page 1 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 employee record review, facility policy review, and staff interview, the facility failed to ensure the State Nurse Aide Registry was checked prior to employment for 1 of 3 CNAs reviewed (CNA #1). The findings were: 1. CNA #1 was re-hired on 8/30/15. Review of the employee file failed to show the CNA abuse registry was verified prior to this date. 2. Review of the facility's policy titled "Abuse, Neglect, and Misappropriation of Resident Property Prohibition" showed, under the section titled "Screening...The Center verifies licensure via licensing agencies and appropriate registries."	F 225	F225 Cont'd: shall be taken to the Quality Assurance Committee at least monthly until such time as Committee deems it appropriate for less frequency.	

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F 225	Continued From page 2 3. Interview with the DON on 11/5/15 at 2:35 PM confirmed the facility was unable to produce evidence the State Nurse Aide Registry was checked for CNA #1 prior to hire.	F 225	F226 Abuse training shall be given to C NA #3, C NA #5 and Housekeeper #1 and documentation placed in personnel files. (Dietary staff #1 is no longer employed)	12-14-15
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of employee files, facility policy review, and staff interview, the facility failed to implement policies and procedures for training employees regarding abuse for 4 of 7 employee files reviewed (CNA #3, CNA #5, dietary staff #1, housekeeper #1). The findings were: 1. Interview with the administrator on 11/4/15 at 7 PM revealed no documentation, other than an orientation checklist was available, to show abuse training was completed prior to resident contact. Review of the following employee files showed no evidence of abuse training at orientation or prior to first date of resident contact: CNA #5, dietary staff #1, CNA #3, housekeeper #1. 2. Interview with the DON on 11/5/15 at 2:35 PM confirmed that the "Abuse Education Training" verification was not in the above-named employee files for CNA #5, dietary staff #1, CNA #3 or housekeeper #1.	F 226	Identification of Others: Business Office Manager and/or designee shall review all personnel files to determine all abuse training documentation is present. Systemic Changes: Staff Development Coordinator shall implement training for staff not having the documentation in their file. Training shall be documented and included in the files. Monitoring: Staff Development Coordinator shall audit new hire personnel files for training and documentation being completed for all new hires. Audits shall be completed for all new hires. Audits shall be taken to the Quality Assurance Committee at least monthly until it is deemed appropriate less frequently.	

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F 226	Continued From page 3 3. Review of the facility's policy titled "Abuse, Neglect, and Misappropriation of Resident Property Prohibition" showed "Training: a) The Center trains each employee regarding the abuse prohibition policies and related polices and processes. b) The Center confirms that training is provided during orientation and annually and more often as determined by the Center."	F 226	F241 Resident #35 was interviewed by Social Services and no negative phychosocial result was noted related to this observation. Identification of Others: Social Services shall interview other residents to validate they have been treated with dignity. Anyone who states they have not been treated with dignity shall have follow-up investigation completed. Systemic Changes: Staff Development Coordinator and/or designee shall provide education relating to dignity and respect of individuality as relating to communicating what care is being provided and communicating with respect as well as dignity and respect training, using PRIDE inservice tool, to staff in each department. Monitoring: Staff Development Coordinator and/or designee shall complete weekly random audits by observation for staff interaction with residents. Any inappropriate interaction shall be corrected at the observed time. Audits shall be taken to the Quality Assurance Committee at least monthly until it is deemed less frequency is appropriate.	12-14-15
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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure dignity for 1 of 5 sample residents (#35) during care observations. The findings were: 1. Observation on 11/3/15 at 9:18 AM showed CNA #1 took resident #35 into his/her room to assist the resident to the toilet. The CNA failed to explain to the resident what care was going to be provided. The CNA stated, "Come on. Come [Resident name]." The resident grabbed the bar and stood up. The CNA removed the resident's pants and brief then pushed on the resident's buttocks to guide the resident over the toilet to sit down. After sitting down the resident stated, "Boy, you push me around don't ya." The CNA replied, "Yep. You would push me if you could." The CNA stepped out of the bathroom to gather supplies at which time the resident stood up and urinated on	F 241		

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F 241	Continued From page 4 his/her pants and the floor. The CNA returned to the bathroom and provided perineal care to the resident and again stated, "Sit down. Sit down [resident's name]. Come on, sit down." The resident sat down and the CNA exited the bathroom. The CNA obtained paper towels and entered the bathroom. The CNA cleaned the floor and removed the resident's soiled pants. The CNA stated, "You got it on everything, didn't you." The CNA had the resident stand to provide perineal care and when finished, had the resident sit down on the toilet and stated, "Good [boy/girl]." The CNA got the resident's wheelchair and had the resident grab the bars to stand and the CNA guided the resident to sit in the wheelchair. The CNA pulled the resident's wheelchair out of the bathroom and the resident dragged the soiled pants, which had been left on the bathroom floor, with his/her feet. The CNA stated, "No, leave that there." When the resident complied, the CNA again stated "Good [boy/girl]." 2. Interview with the DON on 11/4/15 at 3:40 PM revealed the CNA should not have spoken to the resident in that way because it was "disrespectful and undignified." 3. Review of the facility policy titled "Resident Bill of Rights" published 7/27/15 showed "Each resident has the right to: A dignified existence..." Additionally the policy stated residents have the right to "Be fully informed in advance about care and treatment..."	F 241	F253 The non-cleanable surfaces on walls, window blinds, radiator cover shall be repaired and/or replaced by Maintenance Director and/or designee. The observed furniture shall be cleaned and/or replaced. The tiles on the front tub room floor shall be replaced as evidenced by the work order, contractor bids, company approval of bids, supplies ordered and contractor scheduled. Identification of Others: Inspection of other areas within the facility will be conducted by the Maintenance Director and/or designee to identify other areas with the observed conditions. Systemic Changes: Maintenance Director shall provide education to staff relating to identifying and reporting any further similar items observed in the survey. Monitoring: Maintenance Director and/or designee shall perform weekly random audits of the facility. Results of the audit shall be taken to the Quality Assurance Committee at least monthly until it is deemed less frequency is appropriate.	12-14-15
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a	F 253		

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F 253	Continued From page 5 sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a sanitary and well-maintained environment in 3 of 3 resident units (Front, Back, and Secured). The findings were: 1. Tour of the facility on 11/5/15 between 10:00 and 10:30 AM revealed the following concerns with the tub rooms: a. Observation of the tub room in the front hall next to room #16 on 11/5/15 at 10 AM showed that the majority of tiles in the room (more than 30 tiles measuring 12 inches by 12 inches) were cracked and badly damaged. There were gaps where sections of the tiles had completely broken away in multiple places, measuring up to 6 inches by 2 ½ inches. Additionally, the edge of the tub facing the doorway was covered in tape that was a dirty, brown color, creating a non-cleanable surface. b. Observation of the tub room in the back hallway on 11/5/15 at 10:10 AM showed that the wall by the door had a section with paint chipped away and a dent in the wall measuring approximately 14 inches long and ¼ inches deep with plaster and metal exposed, creating a non-cleanable surface. 2. Tour of the facility on 11/3/15 and 11/4/15 revealed the following concerns with furniture in the facility: a. Observation of the green rocking chair in the dining area on the secure unit on 11/3/15 at 10:37 AM showed that the chair had white crusted	F 253		

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F 253	Continued From page 6 stains on the front of the seat. b. Observation of the blue arm chair on the secure unit in the dining area on 11/3/15 at 10:37 AM showed there were white crusty-looking stains on the side of the chair. c. Observation of the tan arm chair on the secure unit near the back exit door on 11/3/15 at 10:31 AM showed the chair had some brownish-black stains on the side of the chair. d. Observation of the resident sitting area across from the nurse's station on 11/4/15 at 12:05 PM in the back hallway showed 1 of 3 sofas was badly faded and dingy. Additionally, the carpet in the back seating area had dark stains in multiple areas. 3. Tour of the facility on 11/3/15 and 11/4/15 revealed the following concerns with resident rooms: a. Observation of the bathroom in room #1 on 11/4/15 at 11:24 AM showed that approximately 26 inches up from the floor a section of paint was chipped off the bathroom wall, measuring 26 inches in length. Additionally, there was paint chipped off the edge of the bathroom door with exposed metal measuring 22 inches in length, creating a non-cleanable surface. b. Observation of room #5 on 11/4/15 at 11:20 AM showed there was paint chipped off the bathroom door frame measuring 18 inches in length, exposing metal and creating a non-cleanable surface. c. Observation of room #6 on 11/4/15 at 11:22 AM showed in the bathroom there were 4 small holes in the wall to the left of the toilet, level with the top of the toilet. Also, 15 inches up from the floor, there was a patch of wall measuring 8 inches by 7 inches that had not been repainted, creating a non-cleanable surface.	F 253		

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F 253	Continued From page 7 d. Observation of room #16 on 11/4/15 at 11:29 AM showed the metal cover on the door was peeling back in sections, creating sharp metal edges. e. Observation of room #25 on 11/4/15 at 11:27 AM showed the bathroom radiator had pulled away from the wall by approximately 2 inches, creating a sharp metal edge that was sticking out. f. Observation of room #29 on 11/4/15 at 11:25 AM showed the doorway was missing the transition divider that separated the floor in the room from the floor in the hallway, allowing dirt and debris to build up inside of this space. g. Observation of room #20 on 11/3/15 at 9:55 AM on the secure unit showed the blinds in the right corners of both windows were broken and that there was a section of exposed metal and drywall by the bathroom door, creating a non-cleanable surface. h. Observation of room #7 on 11/4/15 at 11:40 AM showed the baseboard near the bathroom was peeling away from the wall. Additionally, on both sides of the wall on the bathroom doorway, paint had peeled away in sections measuring 11 inches in length, about 5 inches up from the floor, exposing a non-cleanable metal surface. Also, 11 inches up from the floor, the bathroom had a section of plaster peeling off the wall, creating a non-cleanable surface. Additionally, the dresser had paint peeling off 4 of 4 drawers in multiple sections. i. Observation of room #10 on 11/5/15 at 9:48 AM showed the doorway had a threshold with 4 tiles that measured 9 inches by 9 inches that were cracked. j. Observation of room #14 on 11/4/15 at 11:45 AM showed that inside the bathroom, paint	F 253		

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F 253	Continued From page 8 had scraped off the wall, exposing a non-cleanable metal surface measuring 10 inches in length, 5 inches up from the floor. k. Observation of room #31 in the back hallway on 11/4/15 at 12:05 PM showed that a section of the blinds were broken in the back left corner of the window. To the right of the sink, 9 inches up from the sink counter, paint had ripped off from the wall exposing an area that measured about 3 ½ inches by 1 ½ inches, creating a surface that was not cleanable. Additionally, the paint was chipped off the closet and the drawers to the right of the sink in numerous sections. l. Observation of room #44 in the back hallway on 11/4/15 at 11:55 AM showed that the paint had peeled off the wall to the right of the mirror, exposing a non-cleanable surface that measured 4 inches by 7 inches. Additionally, the wood at the edge of the wall of the closet had splintered off in a section measuring 24 inches in length. 4. Tour of the facility on 11/4/15 and 11/5/15 revealed the following concerns with other areas in the building: a. Observation of the nurse's station in the back hallway on 11/4/15 at 12:05 PM showed the paint on the corner edge of the wall had chipped away, which exposed a non-cleanable metal surface that measured 18 inches in length, that was 34 inches up from the floor. b. Observation of the radiator in the back hallway by the exit door on 11/5/15 at 9:45 AM showed there were 2 places of metal sticking out approximately 1 inch each, creating sharp edges. c. Observation of the physical therapy room on 11/5/15 at 9:55 AM showed the floor in the center of the room had several stains and streaks of dirt. Additionally, the paint on the wall by the	F 253		

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F 253	Continued From page 9 fire extinguisher had peeled away and bubbled up from the surface, that exposed plaster and created a non-cleanable surface. d. Observation of the tiles in the back hallway on 11/5/15 at 10:13 AM showed that there was a section of tiles that measured 12 inches by 12 inches, with 4 of the tiles cracked and bubbled up, and one tile in the same section that was 7 inches by 12 inches and also cracked. 5. Interview with the maintenance director on 11/5/15 at 11:00 AM revealed that the tiles in the tub room in the front hallway had been installed 3 years ago; however, they were put in incorrectly. He verified the tiles in the room needed to be replaced; however, further interview with the maintenance director verified the facility did not have a written plan of when the tiles in the front tub room would be repaired. 6. Interview with the accounts manager in charge of laundry and housekeeping verified in the seating area in the back hallway, across from the nurse's station, one of the three sofas was stained and dingy and that a second sofa had stains on the arm rest. The accounts manager verified that the sofas were old and needed to be replaced. She stated it had been 3 weeks since the furniture in this area had been cleaned, but added, "They don't get any cleaner." She also verified the carpet in the back seating area was stained and stated, "We get down and spot clean, but it doesn't get really clean." The accounts manager verified the stains on the green rocking chair, the blue arm chair and the tan arm chair in the secure unit dining room area. She said the green rocking chair and blue arm chair had last been cleaned on Monday, 11/2/15, but she was not familiar with the tan arm chair in the corner by	F 253		

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F 253	Continued From page 10 the exit door, and added, "It must be new." She verified the brownish-blackish stains on the side of the tan chair needed to be removed. The accounts manager revealed the corporate interior designer had been to the facility to look at replacing the furniture; however, at that time, there was no written plan or clear time line of when this furniture would be replaced.	F 253	F272 Comprehensive assessments for residents #4,#8,#29,#35,#40,#43, #48, #49, #51,#59, #61, #62 shall be completed. Identification of Others: An audit of residents MDS Assessments completed in the last 30 days shall be performed. Audit of CAA worksheets for analysis shall be completed. Systemic Changes: Education shall be provided by Corporate MDS Coordinator to persons with access to completion of MDS and CAA worksheets. Monitoring: DNS/Designee shall conduct weekly random audits CAA completion according to RQAI schedule for accuracy and analysis. Trends identified through monitoring shall be taken to the Quality Assurance Committee monthly for review by the IDT until a lesser frequency is deemed appropriate.	12-14-15
F 272 SS=F	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding	F 272		

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F 272	Continued From page 11 the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure comprehensive assessments were completed in a variety of triggered areas for 13 of 13 sample residents (#4, #8, #29, #35, #40, #43, #48, #49, #51, #52, #59, #61, #62). The findings were: 1. Review of the annual MDS assessment dated 8/22/15 for resident #4 showed the following areas triggered for further assessment: cognitive loss/dementia, communication, urinary incontinence and indwelling catheter, psychosocial well-being, mood state, behavioral symptoms, activities, falls, nutritional status, and pressure ulcer. Review of the CAAs for the triggered areas showed the description of the impact of the problem/need on the resident and/or the rationale for the care plan decision was not individualized. 2. Review of the admission MDS assessment dated 1/19/15 for resident #8 showed the following areas triggered for further assessment: cognitive loss/dementia, communication, urinary incontinence and indwelling catheter, psychosocial well-being, behavioral symptoms,	F 272		

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F 272	Continued From page 12 activities, falls, nutritional status, dental care, pressure ulcer and psychotropic drug use. Review of the CAAs for the triggered areas showed the description of the impact of the problem/need on the resident and/or the rationale for the care plan decision was not individualized. 3. Review of the comprehensive MDS assessment dated 2/1/15 for resident #29 showed the following areas triggered for further assessment: delirium, cognitive loss/dementia, communication, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, mood state, falls, nutritional status, pressure ulcer and psychotropic drug use. Review of the CAAs for the triggered areas showed the description of the impact of the problem/need on the resident and/or the rationale for the care plan decision was not individualized. 4. Review of the annual MDS assessment dated 5/15/15 for resident #35 showed the following areas triggered for further assessment: delirium, cognitive loss, visual function, communication, urinary incontinence, psychosocial well-being, mood state, behavioral symptoms, activities, falls, nutritional status, pressure ulcers, psychotropic drug use, and pain. Review of the CAAs for the triggered areas showed the description of the impact of the problem/need on the resident and/or the rationale for the care plan decision was not individualized. 5. Review of the annual MDS assessment dated 2/16/15 for resident #40 showed the following areas triggered for further assessment: cognitive loss, ADL function/rehabilitation potential, urinary incontinence, psychosocial well-being, mood state, behavioral symptoms, activities, falls,	F 272		

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F 272	Continued From page 13 pressure ulcers, psychotropic drug use, and return to community referral. Review of the CAAs for the triggered areas showed the description of the impact of the problem/need on the resident and/or the rationale for the care plan decision was not individualized. 6. Review of the annual MDS assessment dated 9/3/15 for resident #43 showed the following areas triggered for further assessment: cognitive loss, communication, ADL function/rehabilitation potential, urinary incontinence, mood state, behavioral symptoms, falls, nutritional status, pressure ulcers, psychotropic drug use, physical restraints, and pain. Review of the CAAs for the triggered areas showed the description of the impact of the problem/need on the resident and/or the rationale for the care plan decision was not individualized. 7. Review of the admission MDS assessment dated 8/4/15 for resident #48 showed the following areas triggered for further assessment: cognitive loss/dementia, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, psychosocial well-being, mood state, activities, falls, dehydration/fluid maintenance, pressure ulcer, and pain. Review of the CAAs for the triggered areas showed the description of the impact of the problem/need on the resident and/or the rationale for the care plan decision was not individualized. 8. Review of the comprehensive MDS assessment dated 8/24/15 for resident #49 showed the following areas triggered for further assessment: cognitive loss/dementia, visual function, communication, ADL	F 272		

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F 272	Continued From page 14 functional/rehabilitation potential, urinary incontinence and indwelling catheter, psychosocial well-being, activities, falls, nutritional status, dental care, and pressure ulcer. Review of the CAAs for the triggered areas showed the description of the impact of the problem/need on the resident and/or the rationale for the care plan decision was not individualized. 9. Review of the annual MDS assessment dated 7/22/15 for resident #51 showed the following areas triggered for further assessment: adl functional/rehabilitation potential, urinary incontinence and indwelling catheter, falls, nutritional status, pressure ulcer, psychotropic drug use, and pain. Review of the CAAs for the triggered areas showed the description of the impact of the problem/need on the resident and/or the rationale for the care plan decision was not individualized. 10. Review of the admission MDS assessment dated 9/15/15 for resident #52 showed the following areas triggered for further assessment: cognitive loss/dementia, communication, urinary incontinence and indwelling catheter, falls, nutritional status, and psychotropic drug use. Review of the CAAs for the triggered areas showed the description of the impact of the problem/need on the resident and/or the rationale for the care plan decision was not individualized. 11. Review of the admission MDS assessment dated 9/14/15 for resident #59 showed the following areas triggered for further assessment: cognitive loss/dementia, adl functional/rehabilitation potential, urinary incontinence and indwelling catheter, psychosocial well-being, mood state, activities,	F 272		

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F 272	Continued From page 15 falls, nutritional status, pressure ulcer, psychotropic drug use, and pain. Review of the CAAs for the triggered areas showed the description of the impact of the problem/need on the resident and/or the rationale for the care plan decision was not individualized. 12. Review of the admission MDS assessment dated 4/14/15 for resident #61 showed the following areas triggered for further assessment: visual function, communication, adl functional/rehabilitation potential, urinary incontinence and indwelling catheter, psychosocial well-being, mood state, activities, falls, nutritional status, pressure ulcer, and psychotropic drug use. Review of the CAAs for the triggered areas showed the description of the impact of the problem/need on the resident and/or the rationale for the care plan decision was not individualized. 13. Review of the admission MDS assessment dated 8/28/15 for resident #62 showed the following areas triggered for further assessment: delirium, cognitive loss/dementia, visual function, communication, urinary incontinence and indwelling catheter, psychosocial well-being, behavioral symptoms, falls, nutritional status, dental care, pressure ulcer, and psychotropic drug use. Review of the CAAs for the triggered areas showed the description of the impact of the problem/need on the resident and/or the rationale for the care plan decision was not individualized. 14. Interview with the Regional MDS Coordinator on 11/4/15 at 6:40 PM revealed the MDS assessments should have the CAA summary completed.	F 272		

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F 275	Continued From page 16	F 275	F275 MDS date for Resident #43 shall be reviewed for the next required MDS to be completed to prevent a late MDS submission. Identification of Others: MDS due dates for other Residents shall be reviewed to prevent a late MDS submission. Systemic Changes: A tracking schedule shall be implemented by the MDS Coordinator at the time of MDS completion relating to the due dates of the next MDS. Monitoring: DNS and/or designee shall complete random audits of the MDS due dates relating to the submission of the next MDS being timely. Audits shall be taken to the Quality Assurance Committee at least monthly until it is deemed appropriate for less frequency.	12-14-15
F 275 SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a comprehensive MDS assessment was completed in a timely manner for 1 of 13 sample residents (#43). The findings were: 1. Review of the significant change MDS assessment for resident #43, completed on 6/18/14, showed the comprehensive assessment had an assessment reference date (ARD) of 6/12/14. Review of completed MDS assessments for the resident showed the next comprehensive assessment was completed on 9/9/15 with an ARD of 9/3/15. The assessment was completed 80 days late. 2. Interview with the regional MDS coordinator on 11/4/15 at 11:45 AM revealed the next comprehensive assessment should have been completed in June 2015 and confirmed it was late.	F 275		
F 279 SS=E	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.	F 279		

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F 279	Continued From page 17 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident interview, and staff interview, the facility failed to develop a comprehensive and individualized care plan for 5 of 13 sample residents (#35, #43, #51, #52, #62). The findings were: 1. Medical record review showed resident #61 was admitted to the facility on 8/12/11 with diagnoses which included dementia and depression. Physician order review showed the resident had a 10/19/15 order for Abilify (antipsychotic) 7.5 milligrams by mouth each day, and a 12/8/14 order for Cymbalta (antidepressant) 60 mg by mouth each morning and 30 mg by mouth at bedtime. Review of the 7/22/15 annual MDS assessment showed on section V the resident triggered for psychotropic drug use and required that area to be addressed	F 279	F279 The care plans for Resident #35, #43, #51, #52 and #62 shall be reviewed and updated to include individualized plans and assessments per the observations. Identification of Others: Care Plans for Residents shall be reviewed to validate they are current and individualized by the IDT team. Systemic Changes: DON and/or designee shall provide education to staff relating to updating can plans and validating they are individualized. Monitoring: DNS and/or designee shall conduct weekly random audits of care plans for appropriate individualization. Audits shall be taken to the Quality Assurance Committee at least monthly until deemed less frequency is appropriate.	12-14-15

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F 279	Continued From page 18 on the care plan. Observation on each day of the survey from 11/2/15 through 11/5/15 showed the resident had clutter on his/her bed which included clothing, a notebook and various papers, a plastic pumpkin container, and a box of Kleenex. Interview with the resident on 11/4/15 at 11:35 AM showed s/he asked staff to clear his/her bed, but usually was told that s/he needed to do it. Interview with CNA #2 on 11/4/15 at 11:40 AM revealed the resident routinely cluttered his/her bed with items, and staff routinely removed those items. The aide stated this had been an ongoing behavioral issue for as long as she could remember. The following issues with the resident's care plan were identified: a. Review of the care plan for "mood problems" last revised on 8/2015 had goals and interventions which included, "[Resident's name] will have improved mood state" and "administer medications as ordered. Monitor/document for side effects and effectiveness;" however, the facility failed to individualize the plan to include which medication the resident was on, what the side effects might be, and how often staff were required to monitor for effectiveness. The plan also failed to identify and specify the resident's strengths and coping skills. b. Review of the care plan for "depression" last revised on 8/20/15 showed goals and interventions which included, "[Resident's name] will exhibit indicators of depression, anxiety or sad mood less than daily by review date" and "administer medications as ordered. Monitor/document for side effects and effectiveness;" however, the facility failed to individualize the plan to include which medication the resident was on, what the side effects might be, and how often staff were required to monitor for effectiveness. The plan also failed to identify	F 279		

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F 279	Continued From page 19 and specify the resident's strengths and coping skills. c. Interview with the DON on 11/5/15 at 9:45 AM confirmed the resident's care plan was not individualized to adequately address the resident's depression and behaviors. 2. Review of the 9/15/15 MDS showed resident #52 was admitted to the facility on 9/3/15 with diagnoses which included fall with hip fracture, had 2 stage II pressure ulcers, and required extensive assistance with bed mobility and transfers. Observation on 11/3/15 at 9:50 AM showed the resident had pressure ulcers that included a stage IV pressure ulcer on his/her entire right heel and a stage IV pressure ulcer over the resident's sacrum which extended into the right and left upper gluteal area and drained dark fluid with a strong odor. Review of the 10/19/15 pressure ulcer log showed the resident had multiple pressure ulcers that included stage III pressure ulcers to the left gluteal, sacral area, coccygeal (coccyx/gluteal) area, right heel, and right great toe. Review of the 10/30/15 pressure ulcer log showed the resident had multiple pressure ulcers that included stage III pressure ulcers to the left and right gluteal, coccyx/sacral area, right great toe, left great toe, and stage IV pressure ulcers to the coccyx/sacral/center and right heel. The following concerns were identified with the resident's care plan: a. Review of the care plan for "pressure ulcer and potential for pressure ulcer development regarding reduced mobility," last revised on 10/29/15, showed goals and interventions that included the resident will have "intact skin, free of redness, blisters, or discoloration by/through review date." and "Administer treatments as ordered and monitor for effectiveness." However,	F 279		

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F 279	Continued From page 20 the facility failed to individualize the plan to include specific interventions for repositioning and off-loading the resident when in his/her wheelchair to include frequency and staff requirements, wound dressing requirements, number of wounds with location and required frequency of assessments with measurements, wound clinic visits to include frequency, and preventative measures which should include the resident's air mattress and wheelchair cushion. b. Interview with the DON on 11/5/15 at 9:45 AM confirmed the facility failed to individualize the resident's care plan to include repositioning and off-loading requirements, how many pressure ulcers the resident had with location, and wound care requirements to include dressings with frequency. 3. Medical record review showed resident #62 was admitted to the facility on 8/5/14 with diagnoses which included dementia. Physician order review showed the resident had a 6/18/15 order for haloperidol (antipsychotic) 5 mg by mouth twice a day. Review of the resident's care plan showed s/he had a plan to address psychotropic medication usage with a goal for the resident to receive the least dosage of the prescribed medication to ensure maximum functional ability both mentally and physically. The interventions included, "Administer medication as ordered. Monitor/document for side effects and effectiveness. Consult with pharmacy, MD to consider dosage reduction when clinically appropriate. Labs per order. Psychiatric/Psychological consult as ordered. Review with IDT [interdisciplinary team] for GDR [gradual dose reduction] as indicated." The following concerns with the resident's care plan were identified:	F 279		

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F 279	Continued From page 21 a. The facility failed to individualize the plan to include the medication ordered and which side effects staff were to monitor, or how often, which should include extrapyramidal symptoms (muscular rigidity, tremor, bradykinesia, and difficulty walking induced by neuroleptic medications; drug-induced Parkinsonism). b. Interview with the DON on 11/5/15 at 9:45 AM confirmed the facility failed to individualize the resident's care plan to include the medication prescribed, side effects and how often the resident should be assessed for potential side effects. 4. Review of the 9/3/15 annual MDS assessment showed resident #43 had diagnoses to include pain and non-psychiatric organic brain damage. Section V of the assessment indicated a care plan was to be developed for pain. Review of the pain care plan, last revised 3/19/15, showed the resident had chronic pain related to generalized pain of unknown origin. The goal developed by the facility was to "administer medications as ordered. See medication record. Monitor for effectiveness and side effect." The facility failed to identify frequency for assessment or non-pharmalogical interventions for pain management. 5. Review of the 5/15/15 annual MDS assessment showed resident #35 had diagnoses to include diabetes mellitus, non-Alzheimer's dementia, and unspecified debility. Section V of the assessment indicated a care plan was to be developed for pain. Review of the pain care plan, initiated on 11/8/14, showed the resident had acute/chronic pain related to trauma to his/her right shoulder from a fall at home. The goal developed by the facility indicated the resident,	F 279		

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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 279	Continued From page 22 "will express verbally or non-verbally demonstrate an acceptable level of pain." Further review showed the interventions included "notify physician if resident is experiencing daily pain greater than his/her acceptable level of pain;" however, the facility failed to identify the acceptable pain level. 6. Interview with the DON on 11/4/15 at 3:40 PM confirmed the care plans were not detailed.	F 279	F309 Pain monitoring shall be implemented for Residents #35 and #43 by DNS to assess level of pain each shift. Identification of Others: IDT team shall review residents for implementation of pain assessments each shift.	12-4-15
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 ensure necessary assessments and monitoring for pain management was implemented for 2 of 7 residents (#35, #43) with pain. The findings were: 1. Review of the care plan for pain, initiated on 11/8/14, showed resident #35 had "acute/chronic pain r/t [related to] right shoulder, from falling out of [his/her] pick-up and frequent falls at home." Further review showed a progress note dated 8/19/15 at 10:34 PM that indicated the resident had an "old cervical clavicular fracture that has not healed." Review of the quarterly MDS	F 309	Systemic Changes: DON and/or designee shall provide education relating to each shift pain assessment documentation Monitoring: DNS and/or designee shall complete weekly random audits relating to daily pain assessments. Audit results shall be taken to the Quality Assurance Committee at least monthly until deemed appropriate for less frequency.	

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	535031	A. BUILDING _____ B. WING _____	C 11/06/2015

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WIND RIVER REHABILITATON AND WELLNESS	1002 FOREST DRIVE RIVERTON, WY 82501

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F 309	Continued From page 23 assessment dated 8/15/15 showed the resident was not on a pain management program. Review of the November 2015 physician orders showed Acetaminophen 325 milligrams (mg) 2 tabs by mouth every 8 hours as needed and Hydrocodone-Acetaminophen 5-325 mg 1 tab every 6 hours as needed were ordered for pain. The following concerns were identified: a. Observation on 11/3/15 at 10:40 AM showed the resident complained of right shoulder pain to LPN #3 stating, "The medication isn't working; However, review of the MAR at 4 PM that day showed no pain medication had been administered to the resident either before or after his/her complaint of pain. b. Review of the August, September, October and November 2015 nursing notes and medication administration record showed the resident received hydrocodone-acetaminophen for pain; but assessment or re-assessment for effective pain management was not completed consistently. This review showed the resident was not assessed and/or re-assessed after Hydrocodone-acetaminophen was administered on 8/15/15, 8/16/15, 8/17/15, 8/21/15, 8/28/15, 9/8/15, 9/18/15, 9/21/15, 9/24/15, 9/28/15, 9/30/15, 10/4/15, 10/19/15, 10/23/15. Further review revealed no documentation of daily pain assessment or non-pharmalogical approaches for relieving pain. 2. Review of the 9/3/15 annual MDS assessment showed resident #43 had diagnoses to include pain and non-psychiatric organic brain damage. Review of the November 2015 physician orders showed Acetaminophen 325 mg 1 tab by mouth twice a day, Ibuprofen 400 mg by mouth twice a day, Acetaminophen 325 mg 1 tab by mouth every 6 hours as needed and	F 309		

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F 309	Continued From page 24 Hydrocodone-Acetaminophen 5-325 mg 1 tab every 8 hours as needed were ordered for pain. The following concerns were identified: a. Review of the CAA showed no rationale or analysis was documented related to pain. Review of the 9/3/15 annual assessment showed the resident experienced pain; however, he/she was unable to answer about pain frequency and effect on function. b. Review of the medical record showed the last pain assessment was initiated 7/23/15 and was not completed. c. Review of the pain care plan last revised 3/19/15 showed the resident had chronic pain related to generalized pain of unknown origin. The goal developed by the facility was to "administer medications as ordered. See medication record. Monitor for effectiveness and side effect." The facility failed to identify frequency for assessment or non-pharmalogical interventions for pain management. d. Review of the MAR for August, September, and October 2015 showed the resident received PRN and scheduled pain medications; however, the facility failed to assess the resident's pain daily. e. Interview with the DON on 11/4/15 at 3:40 PM confirmed that the pain assessment was not completed and did not accurately reflect the resident's pain. 3. Interview with the DON on 11/4/15 at 3:40 PM confirmed that pain assessments should be documented and the facility does not do daily pain assessments.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		

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F 312	Continued From page 25 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of policy and procedures, the facility failed to ensure staff provided appropriate perineal cleaning to a dependent resident during a random observation of bowel incontinence care for 1 resident (#43). The findings were: 1. Review of the annual MDS assessment dated 9/3/15 for resident #43 showed the resident was severely impaired with decision making, always incontinent of urine, frequently incontinent of bowel, and required the total assistance of 2 or more persons for toilet use and personal hygiene. Observation of care on 11/3/15 at 10:12 AM showed the resident was provided perineal care after being incontinent of urine and stool. CNA #1 and the regional MDS coordinator assisted the resident to stand with a mechanical lift and then removed the resident's pants and brief. The regional MDS coordinator began wiping the resident from the back toward the perineal area to remove the fecal matter from the resident. The staff member wiped towards the perineal area 3 times using a seperate wipe each time. After wiping towards the perineal area the staff member reached between the resident's legs and wiped away from the perineal area 2 times using a different wipe each time. The staff member obtained another wipe and cleaned the pubic	F 312	F312 Resident #43 shall be assessed for any symptoms of an infection relating to peri care. Identification of Others: Licensed Nursing staff directed by DNS and/or designee shall assess residents dependent upon staff for peri care for any signs and symptoms of infection. Systemic Changes: Staff Development Coordinator and/or designee shall provide education in proper peri care to staff providing peri care. Monitoring: Staff Development Coordinator and/or designee shall complete weekly random audits of peri care competencies for direct care staff. Audits shall be taken to the Quality Assurance Committee at least monthly until less frequency is deemed appropriate.	12-15-15

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F 312	Continued From page 26 area of the resident. a. Review of the policy titled "Peri-Care, Female" updated May 2015 showed "...separate the labia, clean the area using one downward stroke (front to back)...Clean rectal/peri-area from [vagina/scrotum] to anus in one downward wipe. Repeat until clean..." b. Interview with the regional MDS coordinator on 11/3/15 at 10:12 AM confirmed she was wiping towards the front and it could be a concern. c. Interview with the DON on 11/4/15 at 3:40 PM confirmed that perineal care should be performed from front to back and cleanest to dirtiest.	F 312	F314 Resident #52 no longer resides in the facility. Identification of Others: DNS and/or designee shall review care plans and documentation of Residents with pressure ulcers to validate that policy is being followed and correct documentation is in place. Systemic Changes: DNS and/or designee shall provide education to license nurse staff relating to skin policy and procedure including care plans and documentation. Monitoring: DNS and/or designee shall conduct weekly random audits care plans, predictive indicators and other documentation relating to pressure ulcers. Audits shall be taken to the Quality Assurance Committee at least monthly until deems less frequency is appropriate.	12-4-15
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 observation, medical record review, and staff interview, the facility failed to ensure adequate pressure ulcer care for 1 of 2 sample residents (#52) reviewed for pressure ulcers. The findings were: Medical record review showed resident #52 was	F 314		

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WIND RIVER REHABILITATON AND WELLNESS	1602 FOREST DRIVE RIVERTON, WY 82501

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F 314	Continued From page 27	F 314		

admitted to the facility on 9/3/15 with diagnoses which included fall with hip fracture. Review of the 9/15/15 admission MDS assessment showed the resident had 2 stage II pressure ulcers. The review showed staff were required to provide extensive assistance with bed mobility and transfers. Review of the 10/19/15 pressure ulcer log for the resident showed s/he had the following pressure ulcers: 1 stage III pressure ulcer to the left gluteal that measured 1.1 centimeters by 0.7 centimeters by 0.1 centimeters, 1 stage III pressure ulcer to the sacral area that measured 9.5 centimeters by 3.2 centimeters by 0.1 centimeters, 1 stage III pressure ulcer to the coccygeal (coccyx/gluteal) area that measured 3.5 centimeters by 3.2 centimeters by 0.1 centimeters, 1 stage III pressure ulcer to the right heel that measured 4centimeters by 2.5centimeters by 0.1centimeters, and 1 stage III pressure ulcer to the right great toe that measured 0.8 centimeters by 1.5 cenimeters by 0.1 centimeters. Each wound had the dressing type. Review of the 10/30/15 pressure ulcer log for the resident showed s/he had the following pressure ulcers: 2 stage III pressure ulcers to the left gluteal that measured 4 centimeters by 1 millimeters by 0.1 centimeters and 5.2 centimeters by 3 centimeters by 0.1 millimeters, 2 stage III pressure ulcers to the right gluteal that measured 1 centimeters oval/1 millimeters and 1.3 centimeters oval/0.2 millimeters, 1 stage IV pressure ulcer to the coccyx/sacral/center that measured 7 centimeters diagonal/oval, 2 stage III pressure ulcers to the coccyx/sacral area that measured 3 centimeters oval and 5.5 centimeters oval, 1 stage III pressure ulcer to the right great toe that measured oval 2.5 centimeters by 2.3 centimeters scabbed site, 1 stage III pressure ulcer to the left great toe that measured 3

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F 314	Continued From page 28 centimeters diagonal scabbed, and 1 stage IV pressure ulcer to the right heel that measured 10 centimeters by 7 centimeters by 0.4 centimeters. The review showed consults concerning the wounds with a wound specialist on 9/22/15, 10/12/15, and 10/15/15. The resident was placed on hospice care on 10/15/15. The following issues were identified regarding pressure ulcer care: a. Observation on 11/3/15 at 9:50 AM showed CNA #2 and LPN #1 performed pressure ulcer care for resident #62 in his/her bed. The observation showed the resident had 2 primary pressure ulcers, a stage IV pressure ulcer covering the entire right heel, and a stage IV pressure ulcer covering the sacral area and into the right and left upper gluteal area. The pressure ulcer to the right heel was blackened in the center, and pinkish around the blacked area with defined borders. The pressure ulcer on the sacral area was oozing dark fluid with a strong odor, and was blackened in a portion of the center. The borders were not well-defined. The resident also had a dressing on the right great toe that was not changed at that time. Interview with LPN #1 at that time confirmed the two observed pressure ulcers were multiple existing pressure ulcers that had advanced to create the 1 sacral and 1 right heel pressure ulcer. b. Nursing note review showed the following chronology concerning the resident's wounds: A 9/7/15 note at 11:09 AM documented, "Suture intact to left hip no redness some serous drainage noted to area." A 9/10/15 note at 4:14 AM documented, "Dressings intact to all wounds at this time. L [left] femur staples intact count is 19, incision clean, no drainage at this time, no fever, no redness." A 9/11/15 note at 3:37 PM documented, "Dressings intact to wounds at this	F 314		

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F 314	Continued From page 29	F 314		

time. L femur staples intact count is 19, incision clean, no drainage at this time, no fever, no redness...There is some weeping from L [left] lower extremity. MD called and left message about 2+ edema and weeping to lower extremity." A 9/16/15 note at 1:55 PM documented, "Numerous bruising on hands and arms. Left outer foot 1cm (centimeters) x 1cm stage II PU [pressure ulcer] covered with dressing. Coccyx area 1cm x 1cm stage II covered with dressing. Left thigh open area, covered with dressing. Left trochanter (hip) surgical incision staples intact without redness or drainage..." A 10/15/15 note not timed documented, "New orders from wound care clinic mepilex border and multidex gel to coccyx area change q3d [every 3 days] and PRN-gauze to right great toe q3d and PRN." A 10/18/15 note at 9 AM documented, "Changed dressing to R [right] toe and heel." A 10/30/15 noted documented, "drsng [dressing] change coccyx and right heel." The facility failed to consistently document each pressure ulcer, and describe and measure the pressure ulcers.

c. Review of the Braden assessments (pressure ulcer risk) on 9/10/15 and 9/15/15 showed the resident was "at risk" for a pressure ulcer. The 9/29/15 Braden assessment showed the resident was at "moderate risk" for a pressure ulcer. The facility failed to place the resident at high risk for pressure ulcers; however, the 9/15/15 admission MDS assessment confirmed the resident already had 2 stage II pressure ulcers, was recovering from a fractured hip, and required extensive assist from staff with bed mobility and transfers. The corresponding skin inspection anatomy diagram dated 9/15/15 documented the following " left elbow 0.5 centimeters by 0.5 centimeters stage N/A, coccyx pressure 1 centimeter by 1centimeters stage II,

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F 314	Continued From page 30 left trochanter (hip) sugical incision 14 centimeters by 0.5 centimeters stage II, right hand skin tear 0.25 centimeters by 0.25 centimeters stage N/A, left thigh (rear) type other stage II, right toe(s) type other 0.25 centimeters by 0.25 centimeters stage N/A, left outer foot pressure 1 centimeter by 1 centimeter stage II." d. Review of the resident's care plan showed a plan for "pressure ulcer and potential for pressure ulcer development regarding reduced mobility" last revised on 10/29/15. The goal was for the resident to have "intact skin, free of redness, blisters, or discoloration by/through review date." The interventions included, "Administer treatments as ordered and monitor for effectiveness. Apply moisture to my skin after bathing. Assess/monitor wound healing. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD. Educate [resident's name] as to causes of skin breakdown; including: transfer/repositioning requirements, importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Inform [him/her] of any new areas of skin breakdown. Monitor dressing to ensure it is intact and adhering. Report loose dressing to nurse. Monitor nutritional status. Serve diet as ordered, monitor intake and record. Monitor/document/report to MD PRN (as needed) changes in skin status: appearance, color, wound healing, s/sx (signs/symptoms) of infection, wound size (length by width by depth), state. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated." The facility failed to individualize the plan to include specific interventions for	F 314		

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F 314	Continued From page 31 repositioning and off loading the resident when in his/her wheelchair to include frequency and staff requirements, wound dressing requirements, number of wounds with location and required frequency of assessments with measurements, wound clinic visits to include frequency, and preventative measures which should include the resident's air mattress and wheelchair cushion. e. Interview with the DON on 11/5/15 at 9:45 AM confirmed the facility failed to individualize the resident's care plan for pressure ulcer interventions. She further confirmed the facility failed to document continuity of care as evidenced by the last documentation on 10/30/15 which showed 10 pressure ulcers instead of the 3 present on the 11/3/15 observation. She stated the facility had sent the resident to a wound care clinic 4 times before discontinuing the visits and placing the resident in hospice care. She confirmed the facility had asked for wound documentation from the wound clinic and the clinic refused, with the exception of wound measurements. She further confirmed the facility failed to ensure continuity of care by documenting the wound clinic visits with the exception of one nursing note dated 10/15/15 that stated the facility received new orders from the wound care clinic.	F 314	F315 Resident #43 shall be assessed for any symptoms of an infection relating to peri care. Identification of Others: Licensed Nursing staff directed by DNS and/or designee shall assess residents dependent upon staff for peri care for any signs and symptoms of infection. Systemic Changes: Staff Development Coordinator and/or designee shall provide education in proper peri care to staff providing peri care. Monitoring: Staff Development Coordinator and/or designee shall complete weekly random audits of pericare competencies for direct care staff. Audits shall be taken to the Quality Assurance Committee at least monthly until less frequency is deemed appropriate.	12-14-15
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	F 315		

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F 315	Continued From page 32 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, staff interview, and review of policy and procedure, the facility failed to ensure appropriate measures to prevent urinary tract infections for 1 of 6 sample residents (#43) who required assistance with incontinence care. The findings were: 1. Review of the annual MDS assessment dated 9/3/15 for resident #43 showed the resident was severely impaired with decision making, always incontinent of urine, frequently incontinent of bowel, and required the total assistance of 2 or more persons for toilet use and personal hygiene. Observation of care on 11/3/15 at 10:12 AM showed the resident was provided perineal care after being incontinent of urine and stool. CNA #1 and regional MDS coordinator assisted the resident to stand with a mechanical lift and then removed the resident's pants and brief. Regional MDS Coordinator began wiping the resident from the back toward the perineal area to remove the fecal matter from the resident. The staff member wiped towards the perineal area 3 times using a seperate wipe each time. After wiping towards the perineal area the staff member reached between the resident's legs and wiped away from the perineal area 2 times using a different wipe each time. The staff member obtained another wipe and cleaned the pubic area of the resident. a. Review of the policy titled "Peri-Care" updated May 2015 showed "...clean the area using one downward stroke (front to	F 315		

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F 315	Continued From page 33 back)...Clean rectal/peri-area from [vagina/scrotum] to anus in one downward wipe. Repeat until clean..." b. Interview with the Regional MDS Coordinator on 11/3/15 at 10:12 AM confirmed she was wiping towards the front and it could be a concern. c. Interview with the DON on 11/4/15 at 3:40 PM confirmed that perineal care should be performed from front to back and cleanest to dirtiest.	F 315	F323 Resident #35 shall be assessed for appropriate interventions are in place relating to falls. Resident #35 care plan shall be updated to include all interventions in place relating to this observation by the IDT team. Identification of Others: A review of assessments for Residents with a risk for falls shall be completed relating to appropriate interventions are in place. A review of care plans for Residents with a risk for falls shall be completed by DNS and/or designee relating to all interventions being documented. Systemic Changes: DNS and/or designee shall provide education to the staff involved in care plan development relating to complete listing of interventions being included in the care plan. Monitoring: DNS and/or designee shall complete a weekly random audit of care plans relating to risk for falls. Audits shall be taken to the Quality Assurance Committee at least monthly until it is deemed appropriate for less frequency.	12-14-15
F 323 SS=G	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, fall investigation report review and staff interview, the facility failed to ensure interventions were implemented/developed to prevent and minimize falls for 1 of 6 sample resident (#35) who had falls. This failure to develop and/or implement fall interventions resulted in repeated falls causing head and facial injuries that required medical intervention. The findings were: 1. Review of the "actual falls" care plan, revised on 8/28/15, showed resident #35 was at high risk for falls related to diabetic neuropathy, poor	F 323		

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F 323	Continued From page 34	F 323		

balance, and poor safety awareness. Review of the 11/3/15 fall evaluation showed the resident was at high risk for falls and an intervention review was required. The following concerns were identified:

a. Review of the 7/26/15 post-fall investigation showed the resident had fallen out of his/her wheelchair at 7 AM that day. Review of the 7/26/15 progress note, timed 8:50 AM showed the resident had been observed reaching for something on the floor while seated in the wheelchair. The resident fell forward out of the wheelchair onto the floor, causing a laceration above the resident's right eyebrow. The resident was transported to the emergency room for evaluation.

b. Review of the 8/20/15 post-fall investigation showed the resident was found on the floor on 8/19/15 at 10:20 AM. The resident was nonverbal, unresponsive, with fixed pupils after being assisted off the floor. The resident was sent to the emergency room for evaluation. Review of the 8/19/15, timed 11:41 PM, progress note showed the resident returned from the emergency room with a diagnosis of concussion and an old cervical spine fracture.

c. Review of the 8/22/15 post-fall investigation showed the resident was witnessed to fall from the wheelchair to the floor on 8/21/15 at 1:35 PM, resulting in a wound to the head. The resident was transported to the emergency room for further evaluation.

d. Review of the resident's care plan for falls showed it was last revised on 8/25/15, and was reviewed on 10/22/15. Interventions revised or added to the care plan on 8/25/15 included the following: "[resident name] is encouraged/reminded to use [his/her] call light for assistance with all transfers including from

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F 323	Continued From page 35 [his/her] bed to [his/her] wheelchair" and "Review of care plan for appropriate and timely interventions." There were no interventions that addressed the resident's tendency to fall forward out of the wheelchair, resulting in head and facial injuries. e. Review of the 9/2/15, timed 11:27 AM, progress note showed "...OT [occupational therapy] has made changes to residents WC [wheelchair], PT [physical therapy] is evaluating. No change of care at this time." f. Review of the 9/3/15, timed 9:57 AM, progress note showed the resident was found on the floor in the television room. The resident had been seated in the wheelchair prior. The resident was bleeding from the head and nose. g. Observation of the resident on 11/3/15 at 10:40 AM showed the resident was leaning forward in the wheelchair, holding his/her right arm, and complaining of pain. Review of the 11/3/15 fall scene investigation report showed the resident "slow rolled out of the wheelchair and landed on the floor" that same day at 1:40 PM. Review of the 11/3/15, timed 1:40 PM, progress note showed the resident had been seated in the wheelchair when another resident moved the wheelchair forward. The movement caused the resident to "roll out" of the wheelchair and land on the floor. The resident was bleeding above the right eye and was sent to the emergency room for evaluation. Review of the 11/3/15, timed 5:20 PM, progress note showed the resident returned from the emergency room with "sutures holding laceration intact." h. Interview with the DON on 11/18/15 at 1:45 PM revealed the the facility failed to identify interventions to prevent falls from the wheelchair and confirmed there were no interventions added to the care plan to prevent future falls from the	F 323		

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F 323	Continued From page 36 wheelchair.	F 323	F368 Evening snacks shall be available and offered to Residents on each of the three units. Identification of Others: Residents have the potential for being affected by this lack of snacks being available. Evening snack shall be available and offered on the three units Systemic Changes: Staff Development Coordinator and/or designee shall coordinate with Dietary Manager in providing education to Dietary and nursing staff to provide and offer evening snacks and documentation of accepting or refusing evening snacks. Monitoring: DNS and/or designee shall audit the provision and offering of evening snacks weekly. Audits shall be taken to the Quality Assurance Committee at least monthly until less frequency is deemed appropriate.	12-14-15
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility failed to ensure residents were offered a bedtime snack as required in 3 of 3 resident areas (front unit, back unit, secure unit). The census was 67. The findings were: 1. Observation on 11/3/15 from 8:45 PM through 10:45 PM showed residents were not offered snacks at either of the 3 nursing areas of the front unit, back unit, and secure unit. 2. During the group interview on 11/3/15 at 1:30	F 368		

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F 388	Continued From page 37 PM, residents stated that the facility does not regularly offer snacks in the evenings. They said that they have to ask for a snack if they want one. 3.Interview with staff member #4 on the secure unit on 11/3/15 at 9:00 PM verified that the residents on the secure unit had not received a snack that evening. The staff member reported dinner had been served late that evening and the residents had peppermint ice cream as a dessert, but had not been offered an additional snack before bed. 4. Interview with the DON on 11/4/15 at 3:40 PM confirmed that all residents should be offered bedtime snacks.	F 388	F387 Resident #43 was seen by the physician on November 4, 2015. Identification of Others: Medical Records shall review Resident records for dates of last physician visits and inform physician of upcoming timeline that needs to be met. Systemic Changes: Medical Records Supervisor shall be provided education relating to the requirement for timely physician visits by the MDS Coordinator.	12-14-15
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure physician visits were made every sixty days as required for 1 of 13 sample residents (#43). The findings were: Review of the medical record showed no	F 387	Monitoring: DON and/or designee shall audit physician visits weekly for timeliness. Audit results shall be taken to the Quality Assurance Committee at least monthly until deemed less frequency is appropriate.	

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F 387	Continued From page 38 evidence the physician made a visit to examine resident #43 from 7/1/15 through 11/4/15 for a total of 125 days. Interview with the DON on 11/5/15 at 2:32 PM verified there was no evidence the physician saw the resident during that time frame.	F 387	F441 C NA #1 shall be provided education by the Staff Development Coordinator relating to the observations. Identification of Others: DON and/or designee shall audit direct care staff relating to the appropriate implementation of the infection control program. Systemic Changes: Staff Development Coordinator and/or designee shall provide education to direct care staff relating to the following the procedures of the infection control program. Monitoring: DON and/or designee shall complete weekly random audits of direct care staff appropriately following the infection control program. Results of audits shall be taken to the Quality Assurance Committee at least monthly until deemed less frequency is appropriate.	12-14-15
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		

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F 441	Continued From page 39 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure infection prevention practices were followed during observation of incontinence care for 1 of 5 sample residents (#35) observed for incontinence care. The findings were: 1. Observation on 11/3/15 at 9:18 AM showed CNA #1 took resident #35 into his/her room to assist the resident to the toilet. the following concerns were identified: a. The CNA did not wash hands upon entering. The resident was positioned in the bathroom where s/he stood up by grabbing the bar. b. The CNA assisted the resident to sit down on the toilet, and left the room. When the CNA entered the bathroom again the resident was standing and had urinated on the floor and his/her pants. The CNA wiped the resident's buttocks and left the bathroom to obtain paper towels. The CNA removed gloves and applied new ones then wiped up the urine on the floor. The CNA then removed the resident's pants and set them on the floor. The CNA grabbed the clean brief with the soiled glove and placed it around the resident's legs. c. The CNA grabbed the wipe container while wearing the soiled gloves and removed wipes to	F 441		

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F 441	Continued From page 40 provide perineal care. The CNA's right hand was used to clean the resident's bowel movement and the left hand held the wipes. The CNA continued to reach into the wipes package with a soiled right hand. After the incontinence care was completed the CNA fastened the brief and touched the back of the resident's shirt with the soiled gloves on. d. The CNA assisted the resident to sit on the toilet and left the bathroom to get the resident's wheelchair. The CNA removed the gloves and assisted the resident to stand and sit in the wheelchair. The CNA then took the resident out of the bathroom and removed the resident's socks that had urine on them without wearing gloves. e. The CNA applied clean pants and socks without performing hand hygiene and then pushed the resident up to the sink and helped the resident wash his/her hands. The resident coughed and the CNA grabbed a paper towel and held it to the resident's mouth and said "spit." The resident spit into the paper towel and the CNA assisted the resident to hold the paper towel. The CNA left the room and went across the hall to the soiled utility room and obtained a mop and bucket. f. The CNA returned to the resident's room, applied gloves, and gathered the soiled linen off the bathroom floor. The CNA carried the soiled linen in the CNA's left hand, without a bag, and walked out of the room and across the hall to the soiled utility room. The CNA switched the soiled linen from the left hand to the right hand then reached into the CNA's pocket and grabbed a key to unlock the soiled utility room door. After unlocking the door, the CNA returned the key into the pocket and switched the soiled linen back to the left hand from the right hand, then used the right hand to open the soiled utility room door. The CNA exited the soiled utility room door and	F 441		

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F 441	Continued From page 41 returned to the resident's room and mopped the bathroom floor. The CNA removed the gloves and grabbed the contaminated mop handle and took the mop and bucket back towards the soiled utility room. An unidentified staff member asked the CNA to clean an area in the hall; the CNA removed the mop by holding the contaminated handle and cleaned the hall floor. g. The CNA took the mop and bucket to the soiled utility room, reached into the pocket and removed the keys, unlocked the door, and placed the mop in the soiled utility room. The CNA left the soiled utility room and entered the clean utility room, then exited without performing hand hygiene, and then touched the resident on the back. h. The CNA walked down the hallway and entered another resident's room and closed the door. 2. Interview with the DON on 11/4/15 at 3:40 PM revealed the CNA should have performed hand hygiene, should not have reached into the wipe container with contaminated gloves on, and should have bagged the soiled linen prior to leaving the resident's room. 3. Review of the policy titled "Peri-Care" updated May 2015 showed "1. Complete hand hygiene. 2. Gather supplies: gloves, disposable wipes, or soap, basin, and washcloths...5. Practice hand hygiene and apply gloves...21. Complete hand hygiene and put on clean gloves. 22. Provide clean, dry linens and incontinence products as needed. assist resident to dress."	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		

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F 514	Continued From page 42 The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure medical record notations were accurate and complete for 1 of 15 sample residents (#52). The findings were: 1. Medical record review showed resident #52 was admitted to the facility on 9/3/15 with diagnoses which included fall with hip fracture. Review of the 9/15/15 admission MDS assessment showed the resident had 2 stage II pressure ulcers. Review of the medical record showed no documentation of the resident appointments at the wound clinic with the exception of a 10/15/15 nursing note not timed that showed the wound clinic had sent orders over for wound care. Interview with the DON on 11/5/15 at 9:45 AM confirmed the facility failed to obtain wound clinic documentation, or document wound clinic visits for the resident. She stated the resident visited the wound clinic four times. 2. Interview with the NHA on 11/2/15 at 3 PM	F 514	F514 The facility shall request records for Resident #52. Identification of Others: Residents who have gone to outside clinics shall have the records reviewed to validate that we have received information and any orders after the visit. Systemic Changes: During the clinical meeting, the Residents who had outside clinic visits shall be reviewed to validate that information was received and noted. Monitoring: Audits shall be completed five days per week during clinical meeting by the clinical team. Audit results shall be taken to the Quality Assurance Committee at least monthly until it is deemed less frequency is appropriate.	12-4-15

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F 514	Continued From page 43 revealed some of the documentation from previous ownership was not available.	F 514		