STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING _____ B. WING _____	11/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARAMIE CARE CENTER	503 S 18TH ST LARAMIE, WY 82070

(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 survey was conducted by Healthcare Licensing and Surveys on 11/16/15 through 11/19/15. The following common abbreviations are used throughout this document: CNA - Certified Nurse Aide DON - Director of Nursing MAR - Medication Administration Record LPN - Licensed Practical Nurse RN - Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	F166 Grievances Corrective Action: Residents #8, 25, 36, and 52 were interviewed regarding their grievance. It was then placed on a Grievance/complaint report form. This was followed up on and reported back to the identified Residents. A Resident council meeting was held on 12/16/2015 Identification: Residents who reside at facility are at potential risk. Systemic changes: If a resident, a resident's representative, or another interested family member of a resident has a complaint, a staff member should encourage and assist the resident, or person acting on the resident's behalf, to file a written grievance with the facility using the Grievance/Complaint report. Grievances and complaints may be submitted orally or in writing. The resident or the person filing the	
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on review of resident grievances, and resident and staff interview, the facility failed to ensure 4 of 5 resident grievances (residents #8, #25, #36, #52) reviewed were resolved. The findings were: During a group interview of 6 residents on 11/17/15 at 3 PM, 3 residents stated they reported concerns to the facility regarding missing personal items or concerns with their rooms. The residents revealed the facility "never did anything" about the concerns. Interview with the social	F 166	grievance or complaint on behalf of the resident should be encouraged to sign the grievance/complaint. The written grievance will be forwarded to the facility's administrator/Designee with- in 24-48 hours of receipt. Upon receipt of a written grievance and/or complaint the Administrator/Designee will refer it to the appropriate department head for investigation. The department head will submit a written report of such findings to the Administrator within 3 working days of receiving the grievance and/ or complaint. The investigation and report should be completed using a grievance/ complaint record. The resident council are additional forums for voicing complaints/grievances. Complaints/ grievances received from these councils will be acted upon in accordance with this procedure. The Department Head that addressed the grievance will then follow up with the resident, or person acting on the resident's behalf. On or prior to the facilities allegation of compliance the NHA/Designee will in-service the Department Head team on the Grievance process and the importance of following up with the resident/family member after the grievance is resolved. The SDC/Designee will in-service staff actively employed at Laramie care center on the Grievance process. Sign in sheets will be kept for each in-service and reconcile with an active staff roster and those unable to attend will be provide 1:1 education.	1/25/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Andrea Stannard | TITLE: NHA | (X6) DATE: 12/3/15

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.

WY Dept of Health
JAN 04 2016
Healthcare Licensing and Surveys

Accepted w/ changes discussed w/ Andrea Stannard NHA on 1/12/16 @ 4pm 1/14/16

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F 166	Continued From page 1 service manager on 11/19/15 at 10:45 AM revealed she was generally the person to document initial grievances, then she would pass on the form to the appropriate department manager to investigate and resolve the grievances. The following concerns were identified: a. Review of a grievance filed on 11/2/15 showed resident #52 had concerns with receiving medications timely and with being provided with enough water to take the medications. Further review showed no evidence the facility followed up with the resident to provide feedback on how the grievance was being resolved. b. Review of a grievance filed on 10/15/15 showed resident #8 had a variety of concerns including waiting for call lights to be answered and family members not being notified of medication changes. Further review showed no evidence all of the concerns were resolved. c. Review of a grievance filed on 10/26/15 showed resident #25 had a complaint that a CNA used a mechanical lift to transfer the resident, with no assistance from another CNA. Further review showed the CNA was trained on proper use of the lift, but there was no evidence the facility followed up with the resident. d. Review of a grievance filed on 10/26/15 showed a family member of resident #36 was concerned the resident was not getting needed assistance during meals. Further review showed no evidence the concern was resolved. e. Interview with the administrator on 11/19/15 at 11:50 AM revealed the follow up process regarding grievances was done verbally. She verified the grievance forms did not show documentation the resident was involved in the resolution.	F 166	Monitoring: The administrator / designee will document grievances on the Grievance/ Complaint QA&A log. This report will be tracked/ trended as part of the facility's QA&A program. The administrator/designee will keep the grievances in a separate binder/folder. Further monitoring of system compliance will occur through resident interviews, resident/family council and ombudsman feedback. Results will be tracked/ trended and reviewed by the facility's QA&A committee to ensure plan had been initiated, sustained and evaluated for effectiveness.	1/25/2016

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F 167	Continued From page 2	F 167	F167 This REGULATION will be met as evidenced by: Correction:	
F 167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the most recent survey results were available to facility residents for review. The findings were: Observation on 11/17/15 at 9:10 AM showed a survey book was available near the front entrance to the facility. In the book there was a copy of the 10/9/14 Federal health and life safety code surveys. However, the complaint survey which was completed on 8/27/15 was not included. Interview with the administrator on 11/18/15 at 5:50 PM revealed she was not aware complaint surveys needed to be included for the residents to review.	F 167	The complaint survey from September 2015, the facilities most recent survey, was placed in the book by the front entrance that is accessible for anyone to view 1. Identification: Residents residing in the facility may be subject to this deficiency. 2. Systemic changes: The facility will ensure that measures and/or systemic changes are put into place will include but not be limited to ensuring that all survey results and approved plan of correction if applicable, are available in a readable form, such as a binder or notebook and have not been altered by the facility unless authorized by the State agency, and are available to residents without having to ask a staff person. The survey results will be placed near front sign in table. The NHA will ensure the binder always has the most recent survey results. 3. Monitoring: The NHA or designee will monitor monthly to ensure the most recent survey results are in the binder and accessible. Issues identified will be corrected at that time. On an annual basis will identifying any patterns and if necessary, a report will be developed and submitted to the Quality Improvement/Quality Management Committee. The facility Quality Assurance Program under the guidance of the Administrator will review the report, and if necessary, will direct an improvement plan. 5. This deficiency shall be corrected by ~~11/18/2015~~.	1/25/2016
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253	F253 Preparation and execution of this response and plan of correction does not constitute an 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 the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with	

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F 253	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure housekeeping and maintenance services were provided to maintain a sanitary and comfortable environment in 3 of 10 hallways (Aspen, South Birch, and Maple). The findings were: 1. Observation on 11/19/15 at 11:10 AM showed the following areas that needed to be maintained and/or repaired: a. The floor in the Aspen hallway from the station 1 nurse's desk to the station 2 nurse's desk (greater than 30 feet in length) had cracked tiles and various-sized gaps in between tiles that exposed a dark surface. The dark surface appeared to have an accumulation of dirt and grime. There were 29 tiles that were cracked. b. Resident rooms #3, #4, #9, and #12 in the South Birch hallway had various-sized gaps in between tiles that exposed a dark surface. The dark surface appeared to have an accumulation of dirt and grime. c. The floor underneath the ice machine in the Maple hallway was not clean and there were 2 cracked and damaged tiles under the front feet of the ice machine. The base of the sink next to the ice machine in this area and the base of the corner wall were damaged and in an un-cleanable condition. 2. Interview with the housekeeping supervisor on 11/19/15 at 11:20 AM verified the cracked tiles and the gaps between tiles were not able to be effectively cleaned, and they needed to be repaired. Interview with the maintenance director	F 253	F253 Preparation and execution of this response and plan of correction does not constitute an 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 the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. 1. CORRECTIVE ACTION: A. Tile from Aspen hallway from the station 1 nurse's desk to the station 2 nurse's desk will be replaced before of date of compliance. B. Resident room #3, #4, #9 and # 12 will be buffed, waxed and deep cleaned. If dark spot still appears tiles will be replaced within day compliance. C. The floor underneath the ice machine in Maple hallway will be cleaned and 2 cracked tiles will be replaced under the front feet. The base of the sink next to ice machine will be repaired or replaced to a cleanable condition. 2. IDENTIFICATION Housekeeping and Maintenance Director conducted visual rounds at the time of survey to identify other potential issues. No other issues were identified. Residents residing at the facility are potentially affected.	1/25/2016

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F 253	Continued From page 4 on 11/19/15 at 11:40 AM verified the condition of the floors made the surfaces un-cleanable and they were in need of repair.	F 253	3. SYSTEMIC CHANGES Housekeeping and Maintenance Director and facility management team will conduct visual rounds to ensure that the facility maintains a sanitary, orderly, and comfortable interior. Administrator/designee will in-service facility staff on communication of maintenance and housekeeping concerns issues via log books located throughout the facility and on the change of condition report. On or before the date of compliance the NHA/designee will In-service housekeeping staff on the importance of cleanliness of the facility. The NHA will provide oversight to ensure identified issues have been resolved.	1/25/2016
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 family and staff interview, the facility failed to perform nursing assessments for 1 of 2 sample residents (#36) with a change in condition. The findings were: Observation of resident #36 on 11/17/15 beginning at 2:50 PM showed the resident was seated in a wheelchair. CNA #1 and CNA #2 entered the room with a mechanical lift and prepared to transfer the resident from the wheelchair to the bed. The resident coughed several times while the CNAs were securing the lift sling. The cough was deep and wet, however, the resident did not cough up any phlegm. The CNAs transferred the resident to the bed, and provided incontinence care. While being cared for on the bed, the resident coughed almost continuously and the CNAs had to raise the head of the bed to assist the resident with breathing. Interview with CNA #1 at that time revealed the	F 309	4. MONITORING The Maintenance Director, Housekeeping Director, and NHA/designee, will conduct monthly environmental rounds in order to identify outstanding housekeeping and maintenance issues with overall oversight provided by the NHA/designee. Findings will be presented to the QA&A monthly for 3 months and as needed. 5. DATE OF COMPLIANCE 1/25/2016	

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F 309	Continued From page 5 resident had been coughing like that for approximately two weeks. The CNA further stated the nurse had been told about the resident's coughing, but the CNA did not know if the resident was being treated for the cough. The following concerns were identified: a. Review of the resident's medical record on 11/17/15 at 3:37 PM showed no evidence a nursing assessment of the resident was completed after the development of the cough, and no evidence the resident's physician had been contacted about the change in condition. Review of the Vital Signs and Weight Record showed the resident's vital signs, including temperature, had last been recorded on 11/3/15 (14 days previous). b. Interview on 11/17/15 at 5:40 PM with LPN #1 revealed the resident had been coughing for about two weeks, but did not have a fever. She added she had discussed the cough with the resident's daughter, and they decided they would "wait and see" if the cough improved. c. Review of the resident's medical record on 11/18/15 at 10:44 AM showed a progress report dated 11/17/15, timed 7 PM, that indicated the resident "has had cough for several days. Moist but unproductive. Afebrile 98 [degrees] and saturations > [greater than] 90 [percent]. Saturation today is 93%. Daughter aware of the symptoms and suggested to continue watching for now. Family is here QD [every day]. This nurse is monitoring resident daily if sx [symptom] worsens. Attempted to call MD [physician] last wk [week] but on hold for now d/t [due to] family req [request]." An additional progress note dated 11/17/15 and timed 7:10 PM showed the resident was "unable to participate during lung assessment each time." d. Interview with a family member on	F 309	F309 Corrective action; a) Resident #36 was evaluated by her physician and assessment was performed. Identification of other residents who may be at risk: a) Residents who reside at facility are at potential risk. On 12/14/ 2015 and continuing up until the allegation of compliance the Nursing administrative staff reviewed the 24-hour reports for the last 14 days to identify residents who may be experiencing a new cough to ensure the cough was assessed and reported as a change in condition to the resident's physician if indicated. No other issues were identified Systemic changes: a) Residents will be assessed on admission, quarterly, annually and with significant changes in condition and/or prn when the residents is experiencing a specific problem and/or has a complaint or describes a new . Nursing staff will be in serviced on the importance of ensure a change of condition with a resident is evaluated/ assessed and documented, and communicated to the MD/Resident/Family when indicated. In servicing will be completed by DON /designee on or before allegation of compliance.	1/25/2016

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F 309	Continued From page 6 11/18/15 at 1:45 PM revealed the resident had been coughing for two weeks. The family member stated they had been told by the resident's nurse the resident did not have a fever, oxygen saturation levels were good, and the resident was getting better. The family member further stated she would definitely want her relative to receive treatment if it was needed. e. During interview on 11/18/15 at 1:40 PM LPN #1 stated she had been monitoring the resident's condition, but confirmed there was no documentation of any assessments. The LPN further stated the resident did not have a fever, indicating she had taken the resident's temperature on 11/13/15, but did not document it. The LPN confirmed the resident had not been assessed for fever (by taking a temperature) since that date. Additionally, the LPN stated the resident was unable to follow instructions and therefore unable to assist with an assessment of lung sounds. The LPN stated the resident's lung sounds were too diminished for her to hear without the resident's assistance (as in taking deep breaths when instructed). The LPN was unable to say if the resident's lung sounds were normally diminished because the facility did "not do regular assessments unless [the resident was] symptomatic."	F 309	Monitoring; a) IDT will review the medical record of residents entered on the 24- hour report as having a change of condition to ensure appropriate timely assessment, documentation, and notification of change of condition has occurred. Continued follow up and review of Residents with condition changes until the resident's condition has stabilized. Nurse Managers will do quality of care rounds three times weekly and prn to identify residents who may be experiencing a change of condition. Issues identified will be followed up on at that time and the trended and reviewed in QA&A to ensure plan is implemented, sustained and evaluated for it's effectiveness. Allegation of compliance: 1/25/2016	1/25/2016
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	F 314		

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F 314	Continued From page 7 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 a resident with a pressure sore received treatment and services to promote healing for 1 of 2 sample residents (#36) with pressure sores. The findings were: Observation of resident #36 on 11/17/15 beginning at 2:50 PM showed the resident was seated in a wheelchair. CNA #1 and CNA #3 transferred the resident from wheelchair to bed with a mechanical lift, and performed incontinence care. Observation of the resident's buttocks at this time showed evidence of resolved pressure sores, and an open, bleeding area approximately 2 cm by 2 cm in size in the area of the left ishial tuberosity. Interview with CNA #1 during the observation revealed the resident was prone to pressure ulcers, so "We keep rotating [him/her] every two hours." CNA #3 stated he would inform the nurse of the resident's wound. The following concerns were identified: a. Review of the resident's medical record on 11/18/15 at 10:44 AM showed no evidence the resident's wound had been assessed or treated. b. Observation of the resident on 11/18/15 beginning at 9:43 AM showed the resident was seated in a wheelchair in his/her room. At 9:55 AM, CNA #4 and LPN #1 entered the resident's room with a mechanical lift and asked the resident if s/he would like to lie down. The resident refused at that time. c. Interview with CNA #4 on 11/18/15 at 9:59	F 314	F314 Corrective action for resident affected: Resident (#36) will continue to receive the care and services necessary to prevent the development of pressure sores and prevent her pressure ulcer from declining; the wound to her ishial tuberosity is improving. The Facility completed the initial wound evaluation for the resident on 11/18/15. Identification: Residents with pressure ulcers are at risk. Prior to the allegation of compliance the DON/Designee reviewed resident records for those residents with pressure ulcers to ensure the wound was assessed and the initial wound evaluation was completed. There were no other issues identified.	1/25/2016

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F 314	Continued From page 8 AM revealed the resident had been showered that morning, and an adhesive dressing was present on the resident's lower left buttock at the time of the shower. The CNA did not know why the adhesive dressing was applied. d. During interview with LPN #1 on 11/18/15 at 9:59 AM, the LPN stated the resident "just gets Skin-Prep [a liquid film-forming dressing that forms a protective film when applied to intact skin]" and did not get any other dressing on the buttock, due to his/her wound being healed. The LPN further stated she had not applied the Skin-Prep yet that day, and she would do it when the resident was laid down. e. Continued observation on 11/18/15 showed the resident was not approached again about lying down until 1:27 PM. The resident was transferred from wheelchair to bed with the use of a mechanical lift. Incontinence care was performed and the resident continued to have an open wound in the area of the left ishial tuberosity. The wound bed was beefy red in color, and no dressing was present. f. Interview with CNA #4 during the observation revealed the resident had been assisted out of bed for a shower between 6:30 AM and 7 AM that day, and had been up in the wheelchair since that time. The CNA further revealed she was not aware the resident had an open wound, and would have encouraged the resident to lay down if she had known. g. Review of the resident's care plan for skin integrity, last reviewed on 11/17/15, showed approaches that included "Locate the source of pressure and remove it" and "Offer repositioning approx. [approximately] q [every] 2-3 hours if resident will allow." h. Interview with LPN #1 on 11/18/15 at 1:40 PM revealed the nurse on duty when a wound is	F 314	Systemic Changes: Beginning 12/14/2015, and continuing up until the allegation of compliance the SDC/Designee In serviced nursing staff on ensuring that newly identified open areas are assessed and the initial wound evaluation is completed according to policy and procedure; Licensed nurses will be in serviced on communicating any newly identified skin issues to the IDT via the 24 hour report. Residents with pressure ulcers will be reviewed daily and the wound progress will be evaluated weekly with corresponding documentation. The DON/Designees will complete reviews of the resident's Treatment Records 3 times weekly and prn for completion of the initial wound .Telephone orders will be reviewed in the morning meeting (stand-up) to review new orders and follow up as needed. Director of Nursing and/or designee will facilitate. Monitoring performance to Ensure Compliance is sustained: The DON/Designee will conduct record reviews 3 times weekly for 1 month, then weekly for three months then prn ongoing to ensure residents who develop wounds are assessed/evaluated and the initial wound evaluation completed per protocol. Results will be reviewed monthly by the QA&A committee to ensure plan is implemented, sustained, and evaluated for its effectiveness. Recommendations will be addressed as needed to ensure continued compliance. Date of compliance 1/25/2016	1/25/2016

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F 314	Continued From page 9 discovered is supposed to complete an initial wound assessment, notify the physician and get treatment orders for the wound, notify the wound nurse, and notify the resident's family. The LPN confirmed she had been the nurse on duty until 6 PM on 11/17/15, and CNA #3 had told her about the resident's wound, but she had not completed the assessment, any of the notifications, or gotten physician orders for treatment because she had forgotten.	F 314	F328 Preparation and execution of this response and plan of correction does not constitute an 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 the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to provide oxygen therapy as needed for 1 of 8 sample residents who used supplemental oxygen (#57). The findings were: Review of the November physician order recapitulation showed resident #57 had orders for "O2 @ 3L/M via NC [oxygen at 3 liters per minute via nasal cannula] for hypoxia [oxygen	F 328	Corrective action: Resident #57 receives oxygen per physicians order as he will allow. Staff were re-educated to ensure 02 tank are not empty by the DON/Designee on 11/19/2015, regarding the importance of ensure the portable 02 concentrators have 02 in them. Identification: Residents requiring O2 are at risk. Systemic: Nursing staff will ensure portable 02 concentrators have an adequate amount of oxygen in the first thing in the morning, before and after each meal and prn. On or before the date of compliance the SDC/Designee will in-service RN's, LPN's and C.N.A's on Oxygen Delivery, specifically ensuring that residents who use oxygen have oxygen in place per the physicians order and the portable 02 concentrators are not empty, specifically the expectation that the o2 tank is checked upon arising, before and after meals and prn. Monitoring: The nurse management staff will do quality of care rounds 3 times weekly and prn to ensure those residents who wear oxygen have it in place per the physicians order and the tanks have 02 in them issues identified will be corrected immediately and trended to be reviewed in QA&A to ensure plan is implemented, sustained and evaluated for it's effectiveness.	DOC 1/25/16 Per Andrea SR

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	535043	A. BUILDING _____ B. WING _____	11/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 328	Continued From page 10 deficiency]." Observation on 11/17/15 at 5:33 PM showed the resident was sitting in the dining room with a portable oxygen tank on the back of the wheelchair. The liter flow on the tank was set at 1 liter per minute. Interview with RN #1 at that time confirmed the tank was set to flow at 1 liter per minute, and verified the resident was supposed to be receiving 3 liters per minute. Additionally, the RN revealed the resident's oxygen tank was empty. The RN measured the resident's oxygen saturation level at 5:37 PM with a pulse oximeter, which showed the resident's oxygen saturation level was low at 85%. The RN provided a full tank of oxygen. Subsequent interview with RN #1, at 5:48 PM, revealed the resident's oxygen saturation level increased to 95% once the oxygen was replaced and the liter flow adjusted. Interview on 11/19/15 at 9:55 AM with the DON revealed her expectation was for portable oxygen tanks to be checked before and after meals, and as needed to ensure they contained oxygen and were at the appropriate setting.	F 328		
F 362 SS=E	483.35(b) SUFFICIENT DIETARY SUPPORT PERSONNEL The facility must employ sufficient support personnel competent to carry out the functions of the dietary service. This REQUIREMENT is not met as evidenced by: Based on observation, review of posted meal times, and resident and staff interview, the facility	F 362		

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F 362	Continued From page 11 failed to ensure meals were served at the scheduled time for 3 of 4 meals observed. The findings were: Review of the posted dining room hours showed breakfast was served at 8 AM, Lunch at 12 PM and Dinner at 5 PM. The posting also showed the doors were opened 15 minutes prior to each meal service. The following concerns were identified: a. On 11/16/15 the lunch meal service in the dining room began at 12:35 PM. b. On 11/17/15 at 8:22 AM the first breakfast meal was served in the dining room. c. On 11/17/15 the first dinner meal served in the dining room was at 5:15 PM. d. During the resident council group interview on 11/17/15 at 3 PM, one resident reported meals sometimes run late and several other group members nodded their heads in agreement. Another resident added, "On average at least 2 meals a day run late." e. Interview on 11/17/15 at 9:02 AM with resident #61 revealed meals were often served "at least 30 minutes" past the scheduled time. The resident added s/he usually went to the dining room late to minimize the time s/he waited for the meal. f. Interview with the dietary manager on 11/18/15 at 11:30 AM verified she was new to her position and was also training a new cook and a new dietary aide. She stated there was a position open for a part time dishwasher/aide. The dietary manager stated the lateness of the meal service was due to learning the process and flow of the meal service.	F 362	F362 This Plan of Correction is submitted as required under State and Federal law. The submission of the Plan of Corrections does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determinations are correct. 1. CORRECTIVE ACTION; Residents will be served meals during scheduled and posted serving times. 2. IDENTIFICATION; All residents are at risk for this practice. 3. SYSTEMIC CHANGES: The Dietary staff was educated by the DM/Designee on or prior to the allegation of compliance on the importance serving meals at the posted serving times. A meal hostess has been provided at each meal to ensure timely serving of meals. The Dietary staff has been education on property prep time and cooking time of each meal to ensure timely serving. 4. MONITORING: The Dietary Director will conduct reviews during the service of at least five meals a week to ensure that the meal was served timely. The results of these reviews will be presented to the facility monthly QA&A meeting for review for a period of six months. Any changes to the policy will be suggested and implemented at that time. 5. This plan of correction will be in place no later than January 25, 2016 1/25/2016	
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE	F 366	F366 This Plan of Correction is submitted as required under State and Federal law. The submission of the Plan of Corrections does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determinations are correct.	

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F 366	Continued From page 12 Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation, review of menus and diet orders, and staff interview, the facility failed to provide an alternative meal choice for 29 residents (#4, #5, #7, #8, #9, #14, #16, #17, #22, #24, #30, #34, #35, #40, #42, #43, #45, #47, #50, #57, #60, #63, #66, #69, #71, #75, #76, #78, #81) with orders for modified diet textures. The findings were: Observation during the noon meal service on 11/18/15 at 11:50 AM showed the main meal option consisted of baked fish, potatoes, bread, and broccoli. The food was prepared in the regular and modified textures of pureed and mechanical soft. The alternative meal consisted of cubed steak, potatoes and gravy, and green beans and was not provided in a modified texture. Review of the menu showed both of these meal options should be available for the mechanical soft and the pureed diets. The following concerns were identified: a. At 12:35 PM the diet card for resident #47 showed the resident had requested the alternative meal option. The dietary manager mentioned the resident would have to be served the main option because the diet order was for mechanical soft texture and that texture was not available for the meal option the resident requested. The resident was served the fish. b. Review of the daily posted lunch and dinner menu selections showed there were 7 options. These included the main and alternate	F 366	1. CORRECTIVE ACTION; residents (#4, #5, #7, #8, #9, #14, #16, #17, #22, #24, #30, #34, #35, #40, #42, #43, #45, #47, #50, #57, #60, #63, #66, #69, #71, #75, #76, #78, #81) Mechanically altered textures including pureed can have the main meal or the alternate meal. 2. IDENTIFICATION; All residents are at risk for this practice. 3. SYSTEMIC CHANGES: The Dietary staff was educated by the DM/Designee on or prior to the allegation of compliance on the importance of ensuring that food is appropriate to the resident according to his/her needs and every resident is offered the opportunity to receive substitutes when refusing foods on the original menu regardless of diet texture. A sign in sheet will be kept and reconciled with active dietary staff and those unable to attend 4. MONITORING the Dietary Director will conduct reviews during the service of at least five meals a week to ensure that the substitutes are being offered. The results of these reviews will be presented to the facility monthly QA&A meeting for review for a period of six months. Any changes to the policy will be suggested and implemented at that time. 5. This plan of correction will be in place no later than January 25, 2015	1/25/2016

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F 366	Continued From page 13 daily hot options, as well as chef salad, cottage cheese and fruit, grilled cheese sandwich, baked potato, and soup of the day. The posting also included the following statement: "The #2 [menu option] is not altered at all. No other options are pureed, and only the #1 [menu option] is made Mech [mechanical] soft." c. Additional interview with the dietary manager on 11/18/15 at 4:50 PM revealed options were not provided in the modified textures due to staff constraints and lack of available room on the steamtable. She verified the residents who were capable of making choices between the menu items should be able to have their preference. d. Review of resident diet order information provided on 11/19/15 showed 14 residents (#4, #8, #9, #16, #17, #22, #24, #40, #57, #60, #63, #71, #76, #81) had orders for pureed texture diets, 1 resident (#35) had orders for pureed meat and the remaining items mechanical, and 14 residents (#5, #7, #14, #30, #34, #42, #43, #45, #47, #50, #66, #69, #75, #78) had orders for mechanical soft texture diets.	F 366		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview the facility failed to ensure food was prepared and served under sanitary conditions in 1 of 1 food preparation areas. The findings were: 1. Observation of the 11/18/15 noon meal preparation and service showed the following concerns with hand washing: a. At 11:43 AM Cook #1 was preparing boiled potatoes and was not wearing any gloves at that time. The cook handled the walk-in refrigerator door to get a cube of butter. Without performing any hand hygiene, the cook proceeded with his bare hands to handle the butter by unwrapping it and adding it to the potatoes. b. At 11:47 AM dietary aide #1 handled the door to the walk-in refrigerator to get ingredients to make sandwiches. The aide was not wearing gloves when she opened the door, and without performing any hand hygiene donned gloves and proceeded with sandwich making. c. Interview on 11/18/15 at 4:50 PM with the dietary manager, administrator and the consultant registered dietitian revealed the manager had noticed some concerns, and additional hand washing education was needed. d. According to Food Code 2013, U.S. Public Health Service, 2-301.14 When to Wash: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms... "(E) After handling soiled EQUIPMENT or UTENSILS...(H) Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands." 2. Observation on 11/16/15 at 11 AM showed the stand mixer was stored; however, it was soiled	F 371	F371 Preparation and execution of this response and plan of correction does not constitute an 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 the provisions of federal and state law require it. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the state operations manual. 1. CORRECTIVE ACTION No residents were named. The areas of the floor identified as being dirty were cleaned on or before date of compliance. All areas mentioned in the 2567 were cleaned on or before the date of compliance. Employees were reeducated to wash hands prior to returning to tray line 12/11/2015 or before date of compliance.	

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F 371	Continued From page 15 with splatters of dried food. The wheels of the carts which held the juice dispenser, convection oven and the stand mixer were soiled with a thick build-up of debris. The outside of the walk-in refrigerator and the 3 rolling bins which contained flour, oatmeal and breadcrumbs were visibly soiled with grime and debris. Observation on 11/18/15 at 12:06 PM showed these items remained unclean. In addition, the following items were identified: a. The bases of two blenders on the center food production table were noted to be soiled with dried food in the crevices and around the operation switches. The blenders were not in use at the time. b. The floor under the service window and around the kitchen edges was not clean, there was build-up of food and debris. There was a cooked egg and part of an English muffin remaining on the floor near the serving line from earlier in the day. c. Interview with the dietary manager, administrator and the consultant registered dietitian on 11/18/15 at 4:50 PM revealed there were cleaning lists available; however the tasks were not always being done. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 3. Observation on 11/18/15 at 11:45 AM showed the specialized utensils used for residents with adaptive eating needs were in poor condition. Seven of these utensils were noted to have material on the handles that was flaking, marred,	F 371	2. IDENTIFICATION Residents that reside at the facility are at risk. 3. SYSTEMIC CHANGES On or before the date of compliance the Food Service Manager/ Designee will in-service dietary staff on food safety and sanitation program specifically on proper hand washing and glove ~~usage during tray line~~, USE, and overall cleanliness of the kitchen. 4. The Dietitian/Designee will complete weekly sanitation rounds times 4 and then monthly and as needed to identify concerns regarding sanitation and until substantial compliance has been met. These issues will also be tracked, trended and the dietary manager will present the results in a report by the FSD/Designee to QA&A monthly for 3 months then as needed for review and suggestions as needed to ensure plan is implemented, sustained and evaluated for its effectiveness. 5. DATE OF COMPLIANCE: January 25/2016	

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F 371	Continued From page 16 gouged, and cracked. The following concerns were identified: a. At 11:47 AM dietary aide #2 used 2 of the utensils to set-up resident #30's room tray. Due to the condition, these utensils were unable to be effectively cleaned and sanitized. b. Interview with the dietary manager, administrator and the consultant registered dietitian on 11/18/15 at 4:50 PM revealed new adaptive utensils were needed. At that time the manager verified 4 residents (#14, #30, #41, #42) in the facility used these types of utensils. c. According to Food Code 2013, U.S. Public Health Service; 4-201.11 "EQUIPMENT and UTENSILS shall be designed and constructed to be durable and to retain their characteristic qualities under normal use conditions.?	F 371	F431 Preparation and execution of this response and plan of correction does not constitute an 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 law, for the purpose of any allegation that the facility is not in substantial compliance with federal requirements of participation. This response and plan of correction constitutes the facility allegation of compliance in accordance with 42 C.F.R & 488.18 and section 7317a of the state operations manual.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431	1) Correction: The bottle of liquid Ativan found in the medication cart not under double lock was immediately refrigerated and locked up. 2) Identification: Residents residing in the facility have the potential to be affected by this practice. 3) Systematic changes: Beginning 12/4/2015 and continuing up until the allegation of compliance the SDC/Designee in serviced RN's and LPN's on the requirement that all medications must be appropriately stored dated and labeled appropriately. Specifically liquid Ativan must be refrigerated in a locked refrigerator in a locked medication room An attendance sheet will be kept and then reconciled with the list of active licensed nursing staff and those unable to attend will receive 1:1 training 4) Monitoring: DON or designee will do weekly medication room and cart reviews to monitor for ongoing compliance. Issues identified will be corrected at that time. Issues will be tracked and trended. DON or designee will report the results to QA&A monthly for the next 3 months and then prn to assure plan is implemented, sustained and evaluated for its effectiveness.	1/25/2016

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F 431	Continued From page 17 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store medications under required refrigeration for 1 of 3 medication carts. The findings were: Observation of the station 3 medication cart on 11/19/15 at 10:35 AM showed a bottle of lorazepam intensol (an anti-anxiety medication and also a controlled medication) was stored in the locked drawer in the medication cart. The bottle was clearly marked with the requirement to keep the bottle stored under refrigeration. Interview with LPN #2 at the time of the observation confirmed the bottle of medication was supposed to be stored in the refrigerator, and further revealed station 3 did not have a secure refrigerator in which to store controlled substances.	F 431		