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Healthcare Licensing

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535050	A. BUILDING _____ B. WING _____	11/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR CARE CENTER	4 NORTH FORK ROAD FORT WASHAKIE, WY 82514

(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 from 11/2/15 to 11/5/15. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living BIMS- Brief Interview for Mental Status CAAs- Care Area Assessments CNA- Certified Nurse Aide DON- Director of Nursing Services MDS- Minimum Data Set MAR- Medication Administration Record LPN- Licensed Practical Nurse RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	**F176** The facility will ensure residents can self-administer drugs if deemed safe. *the interdisciplinary team will complete a self-administration assessment for resident #4 *All current residents will be assessed for self-administration of medication by 12/01/15. *An assessment for self-administration of medication will be completed for all new admits and will be included in the facility new admit packet. *A quality improvement monitoring toll will be implemented by the DON to ensure all residents can self-administer medications if deemed safe. Nursing staff will audit all charts monthly for six months to ensure residents have a completed self-administration assessment and results will be reported quarterly at the QAPI meeting. *Completion Date	12/01/15
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on medical record review, and resident and staff interview, the facility failed to ensure 1 of 1 sample residents (#4) who wished to self-administer medications was evaluated. The findings were: Interview on 11/4/15 at 3:40 PM revealed resident	F 176		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Catherine E Kline
TITLE: Administrator
(X6) DATE: 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.

Accepted on 12/11/15 by Jodee Rhea

DOC = 1/1/16 Catherine Kline, NHA 12/11/15

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F 176	Continued From page 1 #4 wished to keep throat lozenges and other medications available at the bedside for self-administration. The resident stated s/he had talked to the nurses regarding this request. Review of the 7/9/15 admission MDS assessment showed the resident was cognitively intact with a BIMS of 16/15. Interview with RN #1 and the DON on 11/5/15 at 8:10 AM verified it had been known since the resident's admission s/he wanted medications at the bedside. RN #1 further revealed the resident had a physician order to self administer Nitrostat (a medication used to treat chest pain). Review of the 8/4/15 physician's order showed the resident "may carry [his/her] own Nitrostat and will notify nursing staff if [s/he] needs it..." The DON verified an evaluation to determine the safety of the resident self-administering medications had not been completed.	F 176		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, the facility failed to ensure a safe and sanitary environment for 2 of 2 resident hallways (West Wing, East Wing). The findings were: 1. Observation on 11/4/15 beginning at 4 PM and on 11/5/15 at 8:25 AM showed the following concerns related to resident bathrooms: a. The bathroom floor of resident room 202	F 253		

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F 253	Continued From page 2 had 12 inch by 12 inch tiles throughout that were separated, and the gaps were darkened with dirt and debris. Further, the caulking between the toilet and the floor had missing areas, and the gaps were darkened with dirt. b. The bathroom floor of resident room 208 had 12 inch by 12 inch tiles throughout that were separated, and the gaps were darkened with dirt and debris. Further, 4 of 4 corners in the room had an accumulation of loose dirt and debris. c. The bathroom floor of resident room 104 had 12 inch by 12 inch tiles that were separated, and the gaps were darkened with dirt. d. The bathroom floor of resident room 105 had 12 inch by 12 inch tiles that were separated, and the gaps were darkened with dirt. Further, 2 of 4 corners in the room had an accumulation of loose dirt and debris. e. The bathroom floor of resident room 106 had 12 inch by 12 inch tiles throughout that were separated, and the gaps were darkened with dirt. Further, the perimeter of the floor along each wall showed loose dirt and debris accumulating. f. The bathroom floor of resident room 109 had 12 inch by 12 inch tiles that were separated, and the gaps were darkened with dirt. Further, the caulking between the toilet and floor had missing areas, and the gaps were darkened with dirt. 2. Observation of resident room 104 on 11/3/15 at 10:35 AM showed the closet door kick plate was cracked at 5 inches from the bottom right, with a jagged piece sticking out. Further, the door frame on the right edge of the closet was loose and coming off the wall. Interview at that time with the resident of the room revealed "every once in a while they have to come in and push it back on" to the wall. Additional observation showed a	F 253	F253 *1.a Bathroom floors in rooms 202, 208, 104, 105, 106 and 109 will be completely replaced with VCT Tile and all toilets will have new caulking applied between toilets and VCT flooring. 2.a Kick plate and door frame on closet in 104 will be replaced. 3.a The said mechanical lift will have the wheels cleaned and sanitized. *All residents and staff could be affected if infection control isn't maintained from un-sanitized floors. Kick plate and/or frame around closet could cut resident or staff, and mechanical lift if not sanitized could spread infectious disease. Maintenance, housekeeping, and nursing will observe and audit all resident rooms and all lifting equipment once a month. *Environmental manager will in-service housekeeping and maintenance staff on services necessary to maintain a sanitary, orderly, and comfortable interior. The Rehab Coordinator/Admission Manager will in-service nursing. *Environmental manager will report observations and audits to the QAPI committee. *Completion date	12/31/15

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F 253	Continued From page 3 mechanical lift in the room that had an accumulation of hair around the center bolt of each of its four wheels. Observation on 11/5/15 at 8:25 AM showed the lift outside of resident room 104, and the wheels continued to have an accumulation of hair around the center bolt. 3. Interview with the maintenance and housekeeping manager on 11/5/15 at 8:30 AM confirmed the identified bathroom floors were "a problem" that he was concerned about as they were difficult to clean and sanitize appropriately. Additionally, he verified the closet door kickplate and frame in room 104 needed to be fixed. Further, he confirmed the mechanical lift wheels needed to be cleaned. He stated he did not routinely monitor the cleanliness of the mechanical lifts and relied on staff members to report any issues.	F 263	F272 The facility will ensure comprehensive, accurate, standardized reproducible assessments of each resident's functional capacity as required. *CAA's for residents #2, #6, #9, #13, #18, #21, #24, and #31 are closed and cannot be altered. *Going forward, CAA's for triggered areas will be complete and will include an analysis to support the care plan decision. All current resident care plans will be reviewed and updated by 12/01/15 *A new ADON/MDS Coordinator started full-time the week of 11/16/15. MDS 101 training was purchased by the facility	
F 272 SS=E	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;	F 272	from AANAC online and will complete the training by 12/01/15. A resource book, "Care Area Assessments" (ISBN978-1-699146-881-9) was also purchased by the facility as a resource and will used for education purposes for the MDS Coordinator and other appropriate staff. *A quality improvement monitoring tool will be implemented by the DON and ADON/MDS Coordinator to ensure all care plans are complete and up to date. DON and ADON/MDS Coordinator will audit care plans every other month and results reported quarterly to the QAPI committee. *Completion date	12/01/15

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F 272	Continued From page 4 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 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 perform required additional assessment on care areas triggered by the completion of the MDS assessment for 6 of 9 sample residents (#2, #6, #9, #13, #18, #21, #24, #31) with completed comprehensive assessments. The findings were: 1. Review of the 1/29/15 admission MDS assessment for resident #2 showed the following areas triggered, which required a comprehensive assessment: ADL Function/rehabilitation potential, Urinary incontinence, Psychosocial well-being, Activities, Falls, Nutrition, Dental care, Pressure ulcers, and Psychotropic drug use.	F 272		

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F 272	Continued From page 5 Review of the CAAs for these triggered areas showed they were incomplete and lacking an analysis to support the care plan decision. 2. Review of the 9/29/15 admission MDS assessment for resident #6 showed the following areas triggered, which required a comprehensive assessment: Cognitive loss/dementia, Communication, Urinary Incontinence, Psychosocial well-being, Falls, Nutrition, and Pressure ulcers. Review of the CAAs for these triggered areas showed they were incomplete and lacking an analysis to support the care plan decision. 3. Review of the 3/7/15 annual MDS assessment showed resident #9 triggered for further assessment in the areas of: ADL Functional/Rehabilitation Potential, Falls, Nutritional Status, Pressure Ulcers, Psychotropic Drug Use, and Physical Restraints. Review of the CAAs for these triggered areas showed they were incomplete and lacking an analysis to support the care plan decision. 4. Review of the 5/21/15 annual MDS assessment showed resident #13 triggered for further assessment in the areas of: ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Psychosocial Well-Being, Activities, Falls, Nutritional Status, Pressure Ulcers, Psychotropic Drug Use, and Pain. Review of the CAAs for these triggered areas showed they were incomplete and lacking an analysis to support the care plan decision. 5. Review of the 3/7/15 annual MDS assessment showed resident #18 triggered for further	F 272		

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F 272	Continued From page 6 assessment in the areas of: Cognitive Loss/Dementia, Visual Function, Communication, ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Behavioral Symptoms, Nutritional Status, Dental Care, Pressure Ulcers, and Physical Restraints. Review of the CAAs for these triggered areas showed they were incomplete and lacking an analysis to support the care plan decision. 6. Review of the 4/21/15 annual MDS assessment for resident #21 showed the following areas triggered which required a comprehensive assessment: Cognitive loss/dementia, Falls, and Psychotropic drug use. Review of the CAAs for these triggered areas showed they were incomplete and lacking an analysis to support the care plan decision. 7. Review of the 2/23/15 admission MDS assessment for resident #24 showed the following areas triggered which required a comprehensive assessment: ADL function/Rehabilitation potential, Psychosocial well-being, Falls, Nutritional status, and Pressure ulcers. Review of the CAAs for these triggered areas showed they were incomplete and lacking an analysis to support the care plan decision. 8. Review of the 5/8/15 admission MDS assessment showed resident #31 triggered for further assessment in the areas of: Cognitive Loss/Dementia, Psychosocial Well-Being, Falls, Nutritional Status, Pressure Ulcers, and Psychotropic Drug Use. Review of the CAAs for these triggered areas showed they were incomplete and lacking an analysis to support the care plan decision.	F 272		

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F 272	Continued From page 7 9. Interview with the DON on 11/5/15 at 1:15 PM confirmed the CAAs were incomplete and had no summary analysis.	F 272	F279 The facility will ensure a comprehensive care plan for each resident will be created and updated. The facility purchased a reference book, "MDS Care Plans Made Easy (ISBN: 978-01-60146-759-1) to help educate the new MDS Coordinator and interdisciplinary team to develop, review, and revise resident care plans. *The MDS Coordinator and interdisciplinary team will update care plans for residents #2, #4, #6, #13, #18, and #31 by 12/01/15. * The facility will ensure a comprehensive care plan for each resident will be created and updated. *Care plans for all residents will be reviewed every two months with the next scheduled review to be completed 12/01/15. *A quality improvement monitoring tool will be implemented by the DON to ensure comprehensive care plans for all residents are relevant and up to date. Results will be reported to the quarterly QAPI committee. *Completion date	12/01/15
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. 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, and staff interview, the facility failed to ensure comprehensive care plans were developed for 6 of 10 sample residents (#2, #4, #6, #13, #18, #31) in a variety of areas. The findings were: 1. Review of the medical record showed resident	F 279		

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F 279	Continued From page 8 #2 was evaluated related to smoking safety on 10/16/15. Review of the 7/28/15 quarterly MDS assessment showed the resident was independent for all ADLs except bathing. Observation on 11/3/15 at 10:40 AM, and 11/4/15 at 1:20 PM showed the resident was outside smoking. No staff were present. The following concerns were identified: a. Review of a nurse's note dated 10/19/15 at 2:30 PM showed the resident had a wound on the inner left thigh which resembled a cigarette burn. b. Review of the care plan failed to show smoking safety was addressed. 2. Review of the medical record for resident #6 showed s/he was admitted on 9/8/15 and had diagnoses including chronic obstructive pulmonary disease (COPD). Review of a 9/7/15 physician progress note showed the resident also had lung cancer which was being treated palliatively. The progress note showed a hospice consult was pending at that time and the resident was to be admitted to the nursing home. Review of the 9/28/15 admission MDS assessment showed the resident was receiving hospice care while a resident. The following concerns were identified: a. Review of the resident's care plan showed it was an admission care plan and under the areas of mood state, nutrition, and diabetes, the word "hospice" was written in. There were no details provided as to what hospice was to provide. b. Review of the hospice's plan of care, which was faxed to the facility on 11/5/15 and not previously available in the nursing home, showed details of the care the hospice was providing. c. Interview with the DON on 11/4/15 at 5:15 PM verified she was unaware of the requirements	F 279	F279 *Smoking assessment for resident #2 completed on 11/05/15. Care plan for resident #2 was updated on 11/22/15 to include smoking safety. *All residents who smoke will have smoking safety assessments completed with care plan reviews. *Care plans for all residents will be reviewed every two months and PRN with the next scheduled review to be completed 12/01/15. *Completion date *The care plan for resident #6 was updated on 11/22/15 to include the areas of mood state, nutrition, and diabetes. A copy of the Hospice Care plan is attached to the facility care plan in the care plan book located at the nurse's station. *The facility will ensure there is a copy of the Hospice Care plan attached to the facility care plan. *Care plans for all residents will be reviewed every two months with the next scheduled review to be completed 12/01/15. *Completion date	12/01/15 12/01/15

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F 279	Continued From page 9 to have the information coordinated and documented in the resident's record. At that time the DON revealed the resident spent most of his/her days out of the facility with family, and this complicated how the resident received services. 3. Interview on 11/4/15 at 3:40 PM revealed resident #4 wished to keep throat lozenges and other medications available at the bedside for self-administration. The resident stated s/he had talked to the nurses regarding this request. Review of the 7/9/15 admission MDS assessment showed the resident was cognitively intact with a BIMS of 15/15. The following concerns were identified: a. Interview with RN #1 and the DON on 11/5/15 at 8:10 AM verified it had been known since the resident's admission s/he wanted medications at the bedside. b. RN #1 further revealed the resident had a physician order to administer Nitrostat (medication used to treat chest pain). Review of the 8/4/15 physician's order showed the resident "may carry [his/her] own Nitrostat and will notify nursing staff if [s/he] needs it..." c. Review of the resident's care plan failed to show any plan or approaches related to self-medication. 4. Review of the 5/8/15 admission MDS assessment showed resident #31 had diagnoses that included depression. Additionally, review of a 10/15/15 accident/incident report showed the resident had right-sided weakness related to a previous cerebrovascular accident (stroke). The following concerns were identified: a. Review of the CAA Analysis Report showed areas requiring care planning included Cognitive Loss/Dementia and Psychosocial	F 279	F279 continued *The care plan for resident #4 was updated on 11/22/15 to include self-administration of medications. A copy of the Hospice Care is attached to the facility care plan in the care plan book located at the nurse's station. *The facility will ensure there is a copy of the Hospice Care plan attached to the facility care plan. An assessment for self-administration of medication will be completed for all new admits and will be included in the facility new admit packet. *Care plans for all residents will be reviewed every two months with the next scheduled review to be completed 12/01/15. *Completion date *The care plan for resident #31 was updated on 11/23/15 to include information about the discontinuation of the orders for orthotic devices, cognitive loss/dementia, and psychosocial well-being. *The facility will ensure that appropriate orders are in place for all residents and updated. *Care plans for all residents will be reviewed every two months with the next scheduled review to be completed 12/01/15. *Completion date	12/01/15 12/01/15

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F 279	Continued From page 10 Well-Being. However, review of the care plan revealed no comprehensive care planning for these areas. b. Observation of the resident's room on 11/3/15 at 10 AM showed a foot brace on the floor next to the chest of drawers, and signs posted on the wall that read "foot brace...wear when up walking - use shoe horn to get shoe over same" and "Wrist Hand Orthotic...When to wear: 3X [three times] a day 1 hr [hour] each alternate with purple rest hand splint wear." c. Review of the resident's care plan revealed no plan had been developed for the resident's orthotic devices. 5. Review of the 5/21/15 annual MDS assessment showed resident #13 had diagnoses that included anxiety and manic depression. Review of the CAA Analysis Report showed areas requiring care planning included Psychosocial Well-Being, Pain, Activities, and Psychotropic Drug Use. However, review of the care plan revealed no comprehensive care planning for these areas. 6. Review of the 3/7/15 annual MDS assessment showed resident #18 had diagnoses that included hemiplegia and traumatic brain injury. Review of the CAA Analysis Report showed areas requiring care planning included Pain, Visual Function, and Behavioral Symptoms. However, review of the care plan revealed no comprehensive care planning for the areas. 7. Interview with the DON on 11/5/15 at 1:15 PM confirmed the care plans for these residents were incomplete.	F 279	F279 continued *the care plan for resident #13 will be updated by 12/1/15 to include information about psychosocial well-being, pain, activities, and psychotropic drug use. *Care plans for all residents will be reviewed every two months with the next scheduled review to be completed 12/01/15 *Completion date	12/01/15 12/01/15
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		

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MORNING STAR CARE CENTER	4 NORTH FORK ROAD FORT WASHAKIE, WY 82514

(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 280 SS=E	Continued From page 11 PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, the facility failed to update and individualize care plans for 2 of 10 sample residents (#13, #21). The findings were: 1. Review of the 7/24/15 quarterly MDS assessment showed resident #21 was independent for ambulation and had a steady balance. Observation of the resident on 11/3/15 at 10:25 AM showed the resident ambulated without any mobility devices from his/her room to the nurses station. The resident appeared steady. Review of the September 2015 nursing notes	F 280	F280 *The facility will ensure a comprehensive and individualized care plan for each resident will be created and updated. The MDS Coordinator and interdisciplinary team will update comprehensive and individualized care plans for residents' #21 and #13 to include fall interventions, recommendations to prevent future falls and hemodialysis information by 12/01/15. * The facility will ensure a comprehensive care plan for each resident will be created and updated. *Care plans for all residents will be reviewed every two months with the next scheduled review to be completed 12/01/15. *A quality improvement monitoring tool will be implemented by the DON to ensure comprehensive care plans for all residents are relevant and up to date. Results will be reported to the quarterly QAPI committee. *Completion date	12/01/15

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F 280	Continued From page 12 showed the resident had falls on 9/7/15, 9/24/15, and 9/30/15. The following concerns were identified: a. Review of the medical record failed to show any post fall interventions/recommendations by an interdisciplinary team. b. Review of the care plan related to falls and ADLs showed it was last reviewed on 10/2/15. The interventions for ADLs showed the resident occasionally required "assistance of 1-2 at times" for tasks. This care plan also showed the resident would at times refuse cares; however it did not address the non-compliance with using mobility devices. In addition the care plan for falls did not address the refusal to use mobility devices. c. Interview with the DON on 11/5/15 at 10 AM verified there were no new interventions added to the care plan or any documented recommendations made to prevent future falls for this resident. 2. Review of the 5/21/15 annual MDS assessment showed resident #13 had diagnoses that included renal insufficiency. Review of the 8/6/15 fall risk evaluation showed resident #13 was at high risk for falls. Review of the "Accident/Incident Report" dated 10/19/15 showed the resident was found on the floor next to the bed. The following concerns were identified: a. Interview with the DON on 11/4/15 at 5:15 PM revealed additional fall interventions put into place for the resident included a fall mat, but they had not been added to the care plan. b. Observation on 11/3/15 at 1:35 PM showed the resident in bed, with the bed in the low position. No fall mat was observed. c. Review of the care plan for falls, last	F 280		

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F 280	Continued From page 13 reviewed 5/24/15, showed interventions included supervision and assistance with transfers, keeping the call light within reach, education to staff regarding resident's fall risk, and education to the resident regarding safety awareness. The care plan was not updated following the 10/19/15 fall and did not include recommended bed position or a fall mat next to the bed. d. Review of the physician visit note dated 9/15/15 showed the resident had been on dialysis for two years and had a fistula in the right arm. e. Review of the "Hemodialysis" care plan, last reviewed on 5/24/15, showed no mention of the resident's fistula or the requirement that staff avoid taking blood pressures on the right arm because of the fistula. f. Interview with the DON on 11/5/15 at 1:15 PM confirmed the care plan was not comprehensive.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and review of the "Mealtime Plan", the facility failed to ensure the care plan was followed for 1 of 10 (#18) sample residents with a mealtime plan. The findings were: Review of the 3/7/15 annual MDS assessment showed resident #18 had diagnoses that included	F 282		

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F 282	Continued From page 14 hemiplegia and traumatic brain injury, and was totally dependent on staff for eating. Review of a 9/20/13 report from a speech-language pathologist (SLP) revealed the resident was "at high risk for aspiration" due to poor oral motor control and slow swallow reflex. Review of the care plan for nutrition, last reviewed on 10/2/15, showed interventions included "Follow mealtime plan from SLP." Review of the "Mealtime Plan" dated 10/16/14 showed staff were to "Watch for swallow after every bite and cue [resident] if you do not see one. Then remind [resident] to make a second swallow so each bite has two swallows." The following concerns were noted during a meal on 11/4/15: 1. Observation beginning at 12:10 PM showed the resident seated in the dining room. CNA #1 provided sips of pudding-thick liquid via spoon. The CNA waited for the resident to swallow, then provided another sip until the cup was empty; however, at no time was the resident observed to make a second swallow, and the CNA did not cue the resident to swallow twice. 2. Observation at 12:21 PM showed CNA #2 setting a tray containing three bowls of pureed food and two cups of thickened liquid on the table next to the resident. The tray also contained a printed copy of the "Mealtime Plan" for the resident. The CNA sat down and assisted the resident with the meal. The CNA did not cue the resident to make a second swallow at any point during the meal. At 12:45 PM, the CNA provided a bite of mashed potatoes to the resident. The resident manipulated the food in his/her mouth for approximately 10 seconds but had not swallowed when the CNA offered another bite of food. When the resident opened his/her mouth, mashed	F 282	F282 *All nursing staff will be retrained/re-educated on the mealtime plan for resident #18 using verbal and written materials by 12/15/15. *The facility will ensure services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. *Charge nurses will audit one meal a day for one month starting 12/01/15. *A quality improvement monitoring tool will be implemented by the DON to ensure all nursing department employees can assist/feed resident #18 following mealtime plan. Results will be reported to the quarterly QAPI committee. *Completion date	12/01/15

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F 282	Continued From page 15 potatoes were observed on the tongue. The CNA continued to provide the next bite of food to the resident without waiting for the resident to swallow or reminding the resident to make a second swallow. 3. Interview with the DON on 11/5/15 at 11 AM confirmed her expectation was the mealtime plan should be followed at every meal.	F 282	F318 Increase/Prevent decrease in ROM *All CNA's will be retrained on the restorative stretching program for resident #9 by 12/11/15.	
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and resident and staff interview, the facility failed to ensure residents with limited range of motion received appropriate services to prevent further decrease in range of motion for 5 of 5 sample residents (#5, #9, #14, #27, #31) with range of motion limitations. The findings were: 1. Review of the 8/23/15 quarterly MDS assessment showed resident #9 had diagnoses that included multiple sclerosis. Further review showed the resident was totally dependent on staff of 1-2 people for bed mobility, transfers, locomotion, eating, and personal hygiene. Additionally, the resident had range of motion	F 318	*All CNA's will be retrained and documented through signed training logs on the restorative nursing (ROM) program and will be monitored weekly by a designated Restorative nurse and the Rehabilitation Coordinator to ensure programming is consistently carried out 7 days a week. *All residents with implemented Restorative Nursing programs will be monitored weekly to ensure programming is consistently carried out 7 days a week. Restorative Nursing care will be documented on a daily basis by each CNA providing resident programming. *Rehabilitation Coordinator and Restorative Nurse designed will audit the documentation weekly to ensure consistency with programming and provides reports to the quarterly QAPI Committee Completion date	01/01/16

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F 318	Continued From page 16 (ROM) impairment on both sides for upper and lower extremities and had not received restorative nursing for active or passive ROM during the look back period. The following concerns were identified: a. Review of the physical therapy evaluation dated 8/10/15 showed a restorative nursing plan was recommended to address bilateral shoulder, elbow, wrist, hip, and knee stretching related to contractures. b. Interview with the resident on 11/4/15 at 3:45 PM revealed s/he had not been consistently receiving restorative services for stretching. Further, the resident revealed staff would occasionally "take my right arm and stretch it, but not very often." The resident stated s/he had felt stiffer since the restorative program was removed, adding "I feel I could have kept going a little longer" to stay ahead of the disease process. 2. Review of the 8/8/15 quarterly MDS assessment showed resident #31 had a functional limitation in range of motion on one side of both the upper and lower extremities. Review of a 10/15/15 accident/incident report showed the resident had right-sided weakness related to a previous cerebrovascular accident (stroke). The following concerns were identified: a. Observation of the resident's room on 11/3/15 at 10 AM showed a foot brace on the floor next to the chest of drawers, and signs posted on the wall that read "foot brace...wear when up walking - use shoe horn to get shoe over same" and "Wrist Hand Orthotic...When to wear: 3X [three times] a day 1 hr [hour] each alternate with purple rest hand splint wear." b. Review of the resident's care plan showed no care plan was developed for the use of the resident's orthotic devices.	F 318	F318 continued *Resident #31 will be evaluated by a Physical Therapist by 12/4/15 and a restorative nursing program will be established and carried out as appropriate. A care plan will be established to reflect the programming and CNA training will be provided. *All residents who have been placed on a restorative nursing program shall have a care plan in place which reflects the programming. Care plans will be updated as any changes occur, and resident as well as family will be notified of such changes. *All resident care plans will be reviewed by the MDS Coordinator upon any changes in status as well as quarterly. *The QAPI Committee will review and document areas of improvement and of success quarterly. Completion date *Resident #14 has been evaluated by a PT and a restorative nursing program has been established to be carried out 3-5 times per week per plan of care. A care plan will be established to reflect the programming and CNA training will be provided. *All residents who have been placed on a restorative nursing program shall have a care plan in place which reflects the programming. Care plans will be updated as any changes occur, and resident as well as family will be notified of such changes.	01/01/16

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F 318	Continued From page 17 c. Observation of the resident on 11/3/15 at 10:15 AM showed the resident was walking with the assistance of a cane. The resident was not wearing a foot brace and was not wearing a hand orthotic. d. Observation of the resident on 11/3/15 at 11:12 AM showed the resident had just had a shower and was dressed in fresh clothing. The resident was not wearing the foot brace, and was not wearing a hand orthotic. e. Observation of the resident on 11/4/15 at 12 PM showed the resident was not wearing either the foot brace or the hand orthotic. f. Interview with the rehabilitation coordinator on 11/14/15 at 10:50 AM revealed there was no documentation to show whether and when the resident was wearing the orthotic devices. 3. Review of the 8/29/15 quarterly MDS assessment showed resident #14 had a functional limitation in range of motion on one side of both the upper and lower extremities. Review of the care plan showed there was no care plan for restorative nursing. 4. Review of the 3/11/15 annual MDS assessment showed resident #27 had a functional limitation in range of motion on both sides of the upper extremities. Review of the care plan showed there was no care plan for restorative nursing. 5. Review of the 11/3/15 annual MDS assessment showed resident #5 had impairment on one side of both the upper and lower extremities. Review of the care plan showed there was no care plan for restorative nursing. 6. Interview with the rehabilitation coordinator on	F 318	*All resident care plans will be reviewed by the MDS Coordinator upon any changes in status as well as quarterly. *The QAPI Committee will review and document areas of improvement and or success quarterly. Completion date *Resident #27 will be evaluated by a PT by 12/4/15 and a restorative nursing program will be established and carried out as appropriate. A care plan will be established to reflect the programming and CNA training will be provided. *All residents who have been placed on a restorative nursing program shall have a care plan in place which reflects the programming. Care plans will be updated as any changes occur, and resident as well as family will be notified of such changes. *All resident care plans will be reviewed by the MDS Coordinator upon any changes in status as well as quarterly. *The QAPI Committee will review and document areas of improvement and or success quarterly. Completion date	01/01/16 01/01/16

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F 318	Continued From page 18 11/4/15 at 10:50 AM revealed the facility did not have a restorative program that directed the restorative care of residents with range of motion limitations, and had not had a restorative program for over 2 years. Further, the rehabilitation coordinator stated residents #5, #9, #14, #27, and #31 would all benefit from a restorative program, but did not think any residents had declined due to the lack of a restorative nursing program.	F 318	F381 continued *Resident #5 will be by a PT by 12/4/15 and a restorative nursing program will be established and carried out as appropriate. A care plan will be established to reflect the programming and CNA training will be provided. *All residents who have been placed on a restorative nursing program shall have a	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, policy and procedure review, medical record review, and staff interview, the facility failed to ensure incidents were investigated and evaluated to determine safety interventions for 1 of 2 sample residents (#2) who had smoking-related incidents. In addition, the facility failed to ensure interventions were developed and implemented related to falls for 2 of 3 sample residents (#13,#21) who had falls. The findings were: 1. Review of the 7/28/15 quarterly MDS assessment showed resident #2 was independent for ADLs with the exception of bathing, and the resident was cognitively intact	F 323	care plan in place which reflects the programming. Care plans will be updated as any changes occur, and resident as well as family will be notified of such changes. *All resident care plans will be reviewed by the MDS Coordinator upon any changes in status as well as quarterly. *The QAPI Committee will review and document areas of improvement and or success quarterly. Completion date	01/01/16

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F 323	Continued From page 19 with a BIMS of 15. Review of the medical record showed the resident was evaluated related to smoking safety on 10/16/15. The evaluation indicated the facility was to have a care plan in place to direct staff in appropriate smoking protocol for the resident. The following concerns were identified: a. Review of a nurse's note dated 10/19/15 at 2:30 PM showed the resident had a wound on the inner left thigh which resembled a cigarette burn. The 10/22/15 note timed at 2 PM showed the resident stated "it was possibly due to a dropped cigarette." b. Review of the medical record failed to show a new evaluation was done related to smoking safety, and the resident's care plan failed to address smoking safety. c. Observation on 11/3/15 at 10:40 AM, and 11/4/15 at 1:20 PM showed the resident was outside smoking. No staff were present. d. Interview with the DON on 11/4/15 at 5:15 PM verified a new smoking safety assessment was not completed and the care plan did not include information related to smoking and safety. At that time the DON also stated the staff felt the resident was safe to smoke and this was an isolated incident. Further, she verified there were no interventions in place for this resident such as an apron to protect his clothes/skin or being supervised by staff. e. Review of the 9/5/12 "Resident Smoking Policy" showed all residents who choose to smoke shall be evaluated by staff, to determine their ability to smoke safely. "This evaluation shall consider...2. whether supervision is indicated, 3. whether flame-retardant barriers are indicated, 4. whether the resident should have restricted, limited, or unlimited access to smoking materials."	F 323	F323 *The MDS Coordinator and interdisciplinary team will update comprehensive and individualized care plans for resident #2 to include appropriate smoking safety protocol, and for residents #13 and #21 to include fall interventions, recommendations to prevent future falls, and information regarding the residents' refusal to assistive devices by 12/01/15. *The facility will ensure all resident environments remain free of accident hazards as is possible and that each resident receives adequate supervision and assistive devices to prevent accidents. *Care plans for all residents will be reviewed every two months with the next scheduled review to be completed 12/01/15. *A quality improvement monitoring tool will be implemented by the DON to ensure comprehensive care plans for all residents are relevant and up to date. Results will be reported to the quarterly QAPI committee. *Completion date	12/01/15

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F 323	Continued From page 20 2. Review of the 7/24/15 quarterly MDS assessment showed resident #21 was independent for ambulation and had a steady balance. Observation of the resident on 11/3/15 at 10:25 AM showed the resident ambulated without any mobility devices from his/her room to the nurse's station. Review of the September nursing notes showed on 9/7/15, 9/24/15, and 9/30/15 the resident had falls. The following concerns were identified: a. The note for 9/24/15 timed at 2:15 PM showed the resident stated s/he fell and had an injury to the left side of his/her head. The nursing note on 9/24/15 timed at 11:15 PM showed the area to the left side of the resident's head was covered with a Band-Aid. The 9/25/15 note timed at 2 PM showed the resident was sent to Indian Health Services (IHS) for a check-up, and a computerized axial tomography (CT) of the resident's head was done at the hospital, and there were "no issues noted." The note further showed the physician order was for no ambulation without assistance, and the "resident immediately non compliant." b. Review of the 9/30/15 nurse's note, timed at 8:45 PM, showed the resident stated s/he had fallen, and came out to ask for assistance with getting a bandage for a skin tear to his/her arm. The note further showed "Again reminded the resident to use wheelchair." c. Review of the medical record failed to show any post-fall interventions/recommendations were made by an interdisciplinary team. Review of the care plan related to falls and ADLs showed it was last reviewed on 10/2/15. The interventions for ADLs showed the resident required the "assistance of 1 -2 at times" for tasks. This care plan also showed	F 323		

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F 323	Continued From page 21 the resident would at times refuse cares; however it did not address the resident's non-compliance with using mobility devices. In addition, the care plan for falls did not address the refusal to use mobility devices. d. Interview with the DON on 11/5/15 at 10 AM verified she was unable to locate the incident reports for the 9/25/15 and the 9/30/15 falls. She verified after these falls, there were no new interventions added to the care plan or any documented recommendations made to prevent future falls for this resident. 3. Review of the 8/6/15 fall risk evaluation showed resident #13 was at high risk for falls. Review of the "Accident/Incident Report" dated 10/19/15 showed the resident was found on the floor next to the bed. The following concerns were identified: a. Interview with the DON on 11/4/15 at 5:15 PM revealed additional fall interventions put in place after the 10/19/15 fall for the resident included a fall mat. b. Observation on 11/3/15 at 1:35 PM showed the resident in bed, with the bed in the low position. No fall mat was observed. c. Review of the care plan for falls, last reviewed 5/24/15, showed interventions included supervision and assistance with transfers, keeping the call light within reach, education to staff regarding resident's fall risk, and education to the resident regarding safety awareness. The care plan was not updated following the 10/19/15 fall and did not include a recommended bed position or a fall mat next to the bed.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329		

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F 329	Continued From page 22 unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the drug regimen was free of unecessary drugs for 1 non-sample resident (#17). The resident was administered an injectable anti-anxiety medication without a physician's order. The findings were: Review of a nurse's note dated 10/26/15, timed 5:30 PM, for resident #12 showed an intramuscular injection of 0.5 milliliters of Ativan (generic name lorazepam; a controlled	F 329	F329 *The DON initiated an investigation in regards to resident #17 receiving IM Ativan on 10/26/15. DON will meet with the nurse who gave the IM injection on 10/26/15. Resident #17 has not received any further IM injections of Ativan. *the facility will ensure each resident's drug regimen will be free of unnecessary drugs. All single-use does of IM Ativan are accounted for and all resident MARS and orders are reviewed monthly by the pharmacy consultant. The DON will provide an in-service with documented sign in sheets on medication administration, charting, telephone orders, and controlled medications *Floor nurses will count and confirm accuracy of all controlled medications at the beginning and end of every shift and document in the EMAR that the counts have been completed. *Results will be reported quarterly to the QAPI Committee. Completion date	12/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535050	A. BUILDING _____ B. WING _____	11/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 23 anti-anxiety medication) was administered in the resident's right deltoid muscle due to the resident's agitation. No other information, such as the milligrams of medication administered, was included in the note. Review of the medical record showed no physician order for intramuscular Ativan, however, review of physician's orders showed orders originating on 4/3/15 for 0.5 milligrams of lorazepam to be administered by mouth at noon, and 0.5 milligrams of lorazepam to be administered by mouth twice daily as needed. Review of the MAR for October, 2015 showed the following 10/26/15 notation: "0.5 mg [milligrams] administered i.v. [intravenously] right deltoid/unable to keep resident seated X [times] 3 hours." Interview with RN #1 on 11/5/15 at 9:22 AM revealed a vial of injectable lorazepam 2 mg/ml [milligrams per milliliter] was unaccounted for. Further interview at 12:45 PM revealed it could not be determined how much injectable lorazepam had been administered to the resident on 10/26/15 due to the conflicting documentation. Interview with the DON on 11/5/15 at 1:15 PM confirmed injectable and oral medications were not interchangeable, a physician's order was required to administer the injectable lorazepam, and there was no physician's order for injectable lorazepam.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371		

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	535060	A. BUILDING _____ B. WING _____	11/05/2015

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F 371	Continued From page 24 (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of cleaning schedules and temperature logs, the facility failed to ensure sanitation requirements were met in the facility kitchen. The findings were: 1. Observation on 11/2/15 at 3 PM showed the hood vents located above the range and grill were soiled with a build up of grease and dust. Observation on 11/4/15 at 10:50 AM showed the condition of the hood vents remained uncleaned. Interview with the dietary manager on 11/4/15 at 3:10 PM revealed the vents were on a weekly schedule. Review of the weekly schedule showed the hood vents were last cleaned on 10/14/15. 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." 2. Observation during the 11/4/15 noon meal preparation showed at 10:55 AM staff member #1 used a wet wiping cloth to wipe down a food preparation table. The towel was not in the sanitizer solution; it was laying on a counter at the side of the 3 compartment sink. The staff	F 371	F371 1a. The kitchen hood will be completely cleaned and there after once a week. 2a. All wiping clothes when not in use will be kept in the sanitizer container with sanitizer solution in it. 3a. All beverages will be checked in the coolers and refrigerators once daily and any beverage older than 7 days will be disposed. 4a. All foods and beverages will be checked and recorded for safe serving temperatures. B. The Environmental manager and Dietary manager will observe and audit the kitchen hood weekly, wiping clothes will be daily for one month and then after weekly, beverages will be audited daily for age for one month and then after weekly, and food and beverages safe serving temperatures will be audited daily for one month and then after weekly. C. The Dietitian, the Environmental manager and Dietary manager will in-service dietary staff with signed training logs on how to store, prepare, distribute and serve food under sanitary conditions. D. The Environmental manager will report observations and audits of kitchen hood, wiping clothes, outdated beverages, and beverage and food temperatures to the QAPI committee quarterly. Complete date	12/20/15

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F 371	Continued From page 25 member then laid the towel back onto the counter. Interview with the dietary manager on 11/4/15 at 3:10 PM revealed she was aware of the requirement to keep wet towels in the solution. According to Food Code 2013, U.S. Public Health Service: 3-304.14 " ...(B) Cloths in-use for wiping counters and other EQUIPMENT surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under § 4-501.114 ... " 3. Observation on 11/2/15 at 3 PM showed there were 2 beverage pitchers in the cooler. One was labeled "apple juice 10/5/15" and the other was labeled "fruit punch 10/3/15." Interview with staff member #2 at that time revealed the dates were when the juice/beverage was put into the container. The staff member then stated the residents didn't drink much of those flavors. Interview with the dietary manager on 11/4/15 at 3:10 PM revealed she was uncertain how long the juice/beverages could be kept. According to Food Code 2013, U.S. Public Health Service: 3-501.17 "(A)...refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days. 4. Observation during the 11/4/15 noon meal preparation showed at 12:05 PM staff member #3	F 371		

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	535050	A. BUILDING _____ B. WING _____	11/05/2016

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F 371	Continued From page 26 was preparing to serve the meal. Review of the temperature log at that time showed there was nothing recorded for the pureed main item (cheeseburger). At that time the staff member stated he had not taken the temperature of the item. When the temperature was taken it was shown to be 120 degrees Fahrenheit (F). The item was then reheated. According to Food Code 2013, U.S. Public Health Service: 3-501.16 "(A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, potentially hazardous food (time/temperature control for safety food) shall be maintained: " (1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54oC (130oF) or above..."	F 371		
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	F 431		

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F 431	Continued From page 27 applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to establish a system to track controlled drugs in sufficient detail to allow accurate accounting of all controlled medications for 1 of 1 controlled medication management systems. The findings were: Observation of the locked medication room refrigerator on 11/5/16 at 9:22 AM showed 7 vials of lorazepam (a controlled anti-anxiety medication) 2 mg/mL were stored in a box in the refrigerator. Review of the controlled medication count sheet, however, showed 8 vials were supposed to be in the refrigerator. The count sheet further showed 10/11/15 (25 days previous) as the most recent date the medication had been administered, with no additional administrations	F 431	F431 *Floor nurses will count and confirm accuracy of all controlled drugs and other drugs subject to abuse at the beginning and end of every shift and document in the EMAR that the counts have been completed. *The facility will ensure a system is in place to track controlled drugs and others drugs subject to abuse in sufficient detail to allow accurate accounting. *DON will meet with all nurses for an in-service provided by a documented sign in log on accurate accounting of all controlled medications and other drugs subject to abuse. *Results will be reported quarterly to QAPI committee. Completion date	12/15/15

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F 431	Continued From page 28 or waste recorded. Interview with RN #1 at that time confirmed 1 vial of lorazepam was unaccounted for. Further, the RN revealed the locked medication refrigerator and the facility's E-kit (emergency kit) were not checked regularly.	F 431		
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	F 441		

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F 441	Continued From page 29 professional practice. (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 and staff interview, the facility failed to ensure staff followed acceptable infection control practices during 1 of 2 meal observations. The findings were: Observation on 11/4/15 showed the activities manager assisting with serving the noon meal. At 12:27 PM, she opened a packet of ketchup using her teeth, then proceeded to squirt the ketchup onto a resident's plate. Interview with the Infection preventionist on 11/5/15 at 11:15 AM confirmed staff opening condiment packets with their teeth and then applying the condiment to resident food was not appropriate.	F 441	F441 *DON will meet with Activities manager individually to discuss appropriate infection control. *DON will provide an in-service through documents training logs to all staff on acceptable infection control practices. *The facility will maintain and infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The facility will also ensure that all old staff attend the "new employee orientation program" that is scheduled monthly and meets the annual review of infection control practices. *Results will be reported the quarterly QAPI committee. Completion date	12/20/15