Part 1

This was split into two parts because of size

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WY Dept of Health
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Healthcare Licensing and Surveys

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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
	535042	A. BUILDING _____ B. WING _____	C 10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY HEALTHCARE CENTER	60 MAGNOLIA CASPER, WY 82604

(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 complaint survey was conducted in conjunction with the recertification survey by Healthcare Licensing and Surveys on 10/19/15 through 10/22/15. The complaint survey was prompted by complaint intakes WY00001994, WY00002029, WY00002056, WY00002075, WY00002089, WY00002118, WY00002120, and WY00002133. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living BIMS- Brief Interview for Mental Status CNA- Certified Nurse Aide CMA- Certified Medication Aide DON- Director of Nursing 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		
F 153 SS=D	483.10(b)(2) RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility.	F153	1. Residents #74 and #159 have been made aware of their rights to their medical record and the new facility charges for processing medical records. 2. All resident's and responsible parties have been made aware of the policy and procedure for obtaining medical records via letter. 3. Medical Records staff has been educated on the need to maintain an accurate log for records requests, the response to requests and funds charged. 4. An audit of the medical records request log will be completed weekly for a period of 12 weeks and findings reported to QAPI by the DON/Designee. 5. The DON/Designee will report findings to the QAPI monthly for a total of 3 months for recommendations, changes, and continuance.	11/27/15
F 153				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 11/16/15

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. Changes made per phone call with Carly Allgaier, NHA on 11/19/15 @ 10am. POC - 11/27/15. POC accepted. Jennifer Cole, RN QA

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F 153	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on review of facility policy and procedure, fee schedule review, interview with community staff, and review of medical records request information, the facility failed to ensure 2 of 2 residents who made medical records copy requests (#74, #159) were allowed to purchase copies of their medical records at a cost not to exceed the community standard. The findings were; Review of the undated policy and procedure related to releasing and copying medical records showed once authorization was verified for the release of the health information, "9...the facility will assess a fee for copying the records." Review of medical record copy request information provided by the facility on 10/30/15 showed residents #74 and #159 had made requests to have copies made of their records in the past 24 months. The information showed both residents refused to pay the cost determined by the facility. Review of the Fee schedule provided by the facility on 10/29/15 showed it was based on information from the Minnesota Department of Health. The table showed it was for March 2011 and a maximum charge was $1.23 per page and a retrieval charge was $16.24. Interview by phone with a staff member of the Natrona County public library (located in the facility's city) on 10/29/15 at 1:35 PM verified the cost for making photocopies was 10 cents per page for black and white, and 25 cents per page for color copies.	F 153		
F 165 SS=E	483.10(f)(1) RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL	F 165		

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F 165	Continued From page 2 A resident has a right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished. This REQUIREMENT is not met as evidenced by: Based on resident interview, policy and procedure review, and review of resident council meeting minutes, the facility failed to ensure residents on 2 of 5 units (South unit, East unit) were free to voice concerns without fear of discrimination or reprisal. The findings were: 1. Confidential resident interview during the survey from 10/19/15 to 10/22/15 revealed 3 residents who expressed fears and concerns. During each of these interviews the residents expressed fear they would be treated poorly or retaliated against in some way for speaking up and bringing forward their concerns about the staffing and conditions in the facility. The resident fears included not being allowed access to activities and being ignored or treated poorly by staff. 2. One of these residents revealed s/he no longer wanted to mention concerns to staff because "nothing happened" before when s/he made a complaint. The resident expressed fear of retaliation, including having "waited hours for pain medication" after reporting a problem to a nurse. 3. Another of these residents was in tears describing his/her fears regarding negative consequences. The resident expressed frustration that the administration and the staff	F 165	F165 1. Residents in attendance were notified via Resident Council the right to voice grievances without reprisal. 2. All residents and responsible parties were notified of their right to voice grievances without reprisal. 3. All Staff were educated about the residents' right to voice grievances without reprisal. 4. Resident grievances will be reviewed daily to ensure that grievances are addressed promptly. Social Services/Designee will interview random residents to ensure no reprisal occurred. 5. The Social Services/Designee will report findings to the QAPI monthly for a total of 3 months for recommendations, changes, and continuance.	11/27/15

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F 165	Continued From page 3	F 165		

only attend to resident needs promptly while "State" was in the building. The resident stated when the survey team leaves, "it will go back to the same with no one caring and not enough staff."

4. Interview on 10/20/15 at 1 PM during a confidential interview with one of the 3 residents revealed s/he felt activities were withheld as a form of punishment/retaliation for voicing concerns and lodging complaints with the administrative staff.

5. Review of the resident council meeting minutes from 10/7/15 showed this was an issue discussed in the meeting. The minutes showed if a resident "voiced a concern to the aides that concern is not passed on to a nurse so they don't receive the help that they need." The DON was in attendance and according to the notes instructed the residents if this "happens again then they should report this to the unit manager." The notes then showed the concern of staff retaliation "...if you turn staff in there will be retaliation against them from staff. There were no specific instances addressed but the residents in attendance had heard of this happening before." The minutes showed there were 10 total residents in attendance.

6. Interview with the recreation service manager on 10/22/15 at 10:17 AM revealed she was responsible for the resident council meeting minutes and ensuring the grievances were passed on. She verified there was not a formal process to ensure grievances from the group were resolved. She stated the department heads would attend the meetings and respond to the concerns of the group as they were discussed.

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F 165	Continued From page 4 The manager verified some of the same concerns continued month to month and the current process failed to provide feedback to the residents on how the issues were being resolved. 7. Review of the Grievance/Concern policy and procedure revised on 6/19/14 showed it failed to address the resident/complainant being protected from retaliation and reprisal.	F 165		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, policy and procedure review, and staff interview, the facility failed to ensure residents were free from physical restraints for 1 of 1 random observations (non-sample resident #77). The findings were: Review of the MDS assessment dated 10/14/15 showed resident #77 had a BIMS score of 10/15 indicating moderate cognitive impairment. Further it showed the resident required extensive assistance with transfers and ambulation. The resident was independent with locomotion. Mobility devices included wheelchair and walker. Observation on 10/20/15 at 10:45 AM showed the resident was in a recliner with the foot rest elevated. The wheelchair was located next to the recliner located in the common area of the East	F221	1. Resident #77 was assessed using the Physical Device Assessment Tool for safety in recliner. 2. All residents using recliners will be reviewed to assure safety has been assessed. and assessed using the Physical Device Assessment Tool. 3. All nurses will be educated on the need to quarterly and with significant change assess residents using physical devices. 4. DON/Designee will complete visual audits of all residents using recliners will be completed 3 x weekly x 90 days on all units to assure continued safety. 5. The DON/Designee will report findings to the QAPI monthly for a total of 3 months for recommendations, changes, and continuance 11/27/15	

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F 221	Continued From page 5 unit. The resident attempted to sit up in the chair and crawl over the foot rest. The following concerns were identified: a. Continued observation showed again the resident attempted to get out of the recliner. The resident placed his/her right leg on the arm of the chair, and the left leg in a gap between the body of the chair and the elevated footrest. An unidentified staff member approached and encouraged the resident to sit back in the chair and rest, saying "You need to rest. You need to keep you feet up, it's good for your circulation." At 11 AM, the resident turned 90 degrees in the chair dangling his/her feet over the arm of the chair rocking back and forth attempting to get up from the chair. The resident was unable to leave the recliner. An unidentified CNA then assisted the resident from the recliner using a gait belt and 1-person stand pivot to the wheelchair. b. An interview with the East unit manager on 10/22/15 at 12:58 PM confirmed the recliner could be considered a restraint if the resident was unable to get up from the chair as described. c. Review of the policy and procedure entitled: "Abuse Prevention Plan" revised 10/14 showed, "Physical Restraint: Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the individual's body that he/she cannot remove easily and that restricts freedom of movement or normal access to his/her body." Further, it showed, "...Inappropriately locked rooms, wards, or environmental mechanisms that prohibit the individual's free movement."	F 221		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		

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F 225	Continued From page 6 The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, policy and	F 225	1. Residents #100, #137, #75, #89, #95 were assessed and all injuries of unknown origin were invested to determine probable cause and reported if indicated. 2. All residents were reassessed to ensure that there were no other injuries of unknown origin. New findings were investigated and reported if indicated. 3. All staff were educated on the process of investigating injuries of unknown origin to determine probable cause if able and reported if indicated. 4. All incidents are reported to the Administrator and DON and reviewed for reporting criteria. Incidents which are injuries with unknown origin will be audited by the DON/Designee to assure complete investigation was conducted and reported if indicated. 5. The DON/Designee will report findings to the QAPI monthly for a total of 3 months for recommendations, changes, and continuance.	11/27/15

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F 225	Continued From page 7	F 225		

procedure review, and medical record review, the facility failed to ensure randomly identified injuries of unknown origin for 2 sample residents (#100, #137) and 3 non-sample residents (#75, #89, #95) were investigated. In addition, the facility failed to make an initial report and meet the five day follow up report time frame for 1 of 5 reportable incidents reviewed. The findings were:

1. Review of the nurses' notes for September revealed the following injuries for resident #137:

a. Review of the nurse's note dated 9/27/15 showed the nurse documented, "received pt [resident] this am with a telfa [a wound dressing] on her right middle finger." Review of previous notes failed to indicate the cause of the injury. Further, there was no further documentation made available by the facility to show an investigation was conducted to determine the cause of the injury.

b. Review of the nurse's note dated 10/11/15 showed the resident had a "large dark blue bruise involving all of [his/her] left thumb and part of [his/her] left wrist. Unknown cause." Review of the "Internal Investigation Form" dated 10/11/15 showed for description of the incident, it was reported the resident had a bruise on the left thumb and part of the left wrist. Further review of the investigation showed the resident was interviewed on 10/12/15. The resident denied s/he had been abused. The resident further indicated the cause of the injury was unknown. There were no additional interviews conducted with staff. Review of the quarterly MDS assessment dated 9/2/15 showed the resident had a BIMS score of 6/15 indicating severe cognitive impairment.

2. Review of the "Resident Bath List" for August

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through October 2015 showed the following injuries were identified by staff:

a. On 8/4/15 the report showed resident #75 had a bruise on the left forearm. There was no documentation made available to show the cause of the injury had been investigated.

b. On 9/9/15 the report showed resident #89 had a skin issue on the right big toe, the skin issue was not described. Review of the documents provided related to the resident's toe showed on 9/22/15 the resident was seen by the physician. Review of the physician visit note showed the resident had a "black lesion on [his/her] right big toe for several weeks." Further, it showed the resident had decreased sensation from below the knee on the right side related to a stroke. Further review of the provided documents did not show an investigation was conducted related to the original cause of the injury.

c. On 10/8/15 the report showed resident #95 had a bruise on the right thumb. There was no documentation made available to show the cause of the injury had been investigated.

d. On 10/9/15 the report showed resident #100 had a bruise on the left hand and also a skin tear. Review of the MDS assessment dated 10/15/15 showed the resident had diagnoses that included non-Alzheimer's dementia and was severely impaired with daily decision making. Review of the skin impairment care plan showed the resident had fragile skin and lacked safety awareness. The following concerns were identified:

I. Review of a progress note dated 10/11/15 and timed 10:25 AM showed the resident had a skin tear noted to the back of the left hand.

II. Review of the facility internal investigation dated 10/11/15 and reported time of

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10:27 AM showed the skin tear was identified; however, the interview summary with the nurse stated "she doesn't know or have suspicions as to how the wound happened." Further review showed the facility did not feel the skin tear was a result of abuse or neglect; however, the facility failed to identify reasons for the determination.

3. Review of the policy and procedure entitled "Abuse Prevention Plan last revised October 2014 showed, "D. Categories of Abuse;...5. Injuries of Unknown Source: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; AND the injury is suspicious because of the extent of the injury or the location of the injury (IE. the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time."

4. Review of the resident to resident allegation of abuse dated 9/28/15 showed resident #32 and #83 were involved in an incident. Review of the State licensing incident logs showed the initial report was not received by the State licensing division. The five day follow up report was received on 10/7/15 (9 days later). Interview with the administrator on 10/21/15 at 10 AM verified the follow up report was late and did not recall the reason. She further stated she was unaware the State licensing division had not received the initial report, and she did not have record to show it was faxed and received.

F 241 SS=E — 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY — F 241

The facility must promote care for residents in a

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F 241	Continued From page 10 manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident, family and staff interview, the facility failed to promote resident dignity in a variety of areas for 5 of 21 sample residents (#31, #54, #105, #137, #151) and 1 non-sample resident (#138). The findings were: 1. The following dignity concerns were identified for resident #151: a. Observation on 10/19/15 at 7:45 PM showed the resident was seated in a wheelchair which was soiled with dried food and debris. The soiled areas included the wheelchair seat edges and the wheels. The resident was also noted to be wearing pants which were soiled with dried food and crumbs on the legs. Interview with the resident's family member on 10/22/15 at 9:45 AM revealed s/he was concerned there were not adequate numbers of staff to care for his/her family member and others in the facility. The family member revealed residents were not getting showers/baths. The family member further revealed the condition of the resident's wheelchair was dirty when the resident recently went out to an appointment. The family member stated it was "embarrassing." b. Observation of the lunch meal on 10/20/15 beginning at 11:17 AM showed the resident was sitting at a table in the dining room with two other residents. At 11:27 AM, one resident at the table was served the meal. Resident #151 did not get served the meal until 11:49 AM (22 minutes later).	F 241	F241 1. Residents #31, #54, #105, #137, #151, #138 have been monitored and dignity issues noted addressed immediately. 2. All residents are currently being monitored for the highest level of dignity possible. 3. All staff have been educated on the residents' right to dignity and respect including: receiving meals timely, grooming and hygiene, clean clothing, clean wheelchairs and proper communication with residents. 4. The DON/Designee visual audits will be completed 3x weekly on all units at various times/shifts x 90 days: Meal service, nail care, resident appearance and attire, wheelchair cleanliness, and staff verbal interactions with residents. 5. The DON/Designee will report findings to the QAPI monthly for a total of 3 months for recommendations, changes, and continuance.	11/27/15 jc

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	535042	A. BUILDING _____ B. WING _____	C 10/22/2015

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SHEPHERD OF THE VALLEY HEALTHCARE CENTER	60 MAGNOLIA CASPER, WY 82604

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2. Review of the 6/9/15 admission MDS assessment showed resident #105 was cognitively intact with a BIMS score of 15, and required extensive assistance for personal hygiene and bathing. Observation on 10/21/15 at 5:30 PM showed the resident was eating in his/her room. The fingernails on both hands were long and caked with a dark colored substance underneath the long nails. Interview with the resident at that time revealed s/he got a shower about once per week. Interview with the South unit manager on 10/21/15 at 6:30 PM verified the resident's nails were dirty and they were being soaked in order to clean them.

3. The following random observations were made related to dignity for resident #137:

a. Observation on 10/20/15 at 11:55 AM showed the resident was sitting in the dining room. The resident had been served and was eating the noon meal. Five residents were sitting at the table waiting to be served. Interview with the resident at 12:08 PM, revealed s/he questioned why the other individuals had not been served. The resident indicated it was uncomfortable eating while others were waiting to eat. Further, the resident stated while growing up, everyone was served at the same time and they ate together. The remaining residents were served at 12:15 PM, 20 minutes later.

b. Observation on 10/20/15 at 10:30 AM showed the resident was sitting in a wheelchair in the common area watching television and looking at the newspaper. The resident self-propelled to the dining room. The sweatshirt the resident wore appeared discolored with brown spots. During a conversation at 11:10 AM the resident stated the sweatshirt was "dirty" and further indicated s/he

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liked clean clothing. In addition, the resident was holding a stuffed animal that was soiled with discolored spots. The resident stated it "needed a bath."

4. Observation on 10/20/15 at 1:10 PM showed resident #31 was sitting in the hallway outside his/her room. Interview with the resident at that time, revealed s/he had requested assistance to change the incontinence pad at 10 AM, approximately 3 hours earlier. Further observation showed the resident's outer clothing was wet. CNAs #1, #2 then transferred the resident from the wheelchair with a Hoyer lift. The incontinence pad was soaked with urine and the back of the resident's clothing was wet. Review of the annual MDS assessment dated 9/16/15 showed diagnoses to include paraplegia and multiple sclerosis. In addition, the resident was cognitively intact with a BIMS score of 15/15. Further it showed the resident required total assistance with transfers and toilet use.

5. Observation on 10/19/15 at 6 PM showed resident #54 was removed from the dining area while having a behavioral incident. An unidentified staff member removed the resident and stated, "Let's go over here in the corner so you can calm down." The staff member then left the resident in the corner area for 40 minutes.

6. Observation on 10/29/25 at 6:10 PM showed RN #6 asked resident #138 to go into the other room to change a dressing on his/her arm. The resident complied and left the dining room. The other residents at the table were served their dinner trays while the resident was away. Resident #138 returned to the dining room at 6:15 PM and requested a meal and staff did not

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F 241	Continued From page 13 respond. The resident again requested a meal 2 times at 6:25 PM and staff did not respond to the request. The resident requested a meal 3 times at 6:30 PM and a staff member responded by telling the resident "It's coming." The resident received the requested meal at 6:32 PM after all but 2 residents in the dining room had received their meals. 7. Review of the undated policy titled "Dining and Meal Service" showed "...The dining experience will be person centered with the purpose of enhancing each individual patient's/resident's quality of life and being supportive of each individual's needs during dining...8. Individuals at the same table will be served and assisted at the same time..."	F 241		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and review of resident council meeting minutes, the facility failed to ensure resident grievances were resolved for 3 of 3 months (August, September, and October 2015) reviewed. The findings were: During a group interview on 10/20/15 at 9:30 AM 6 of 18 residents in attendance revealed the	F 244		

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F 244	Continued From page 14 facility was not providing feedback and resolution to their concerns. The main concerns that were brought up were the lack of CNAs, lack of baths/showers, and the length of time to get call lights answered. Review of the resident council meeting minutes for August, September and October 2015 showed several concerns which were not resolved as they carried over month to month. The following concerns were identified: a. The concerns for the 8/5/15 meeting showed "need more CNAs." b. The 9/2/15 meeting minutes showed "...call lights take up to an hour or more for them to be answered...wheelchairs are not being cleaned...CNAs making residents go to bed without their teeth being brushed...residents are not receiving fresh linens in the room." c. Review of the 10/7/15 minutes showed "call lights are still not being answered in a timely manner...wheelchairs need to be cleaned more often...towels and washcloths are not getting changed out or cleaned...residents want the facility to keep the shower aides the same and make sure residents get scheduled showers..." d. Interview with the recreation service manager on 10/22/15 at 10:17 AM revealed she was responsible for keeping the resident council meeting minutes and ensuring concerns were passed on. She verified there was not a formal process to ensure grievances were resolved. She stated the department heads would attend the meetings and respond to the concerns of the group as they were discussed. The manager verified some of the same concerns continued month-to-month and the current process failed to provide feedback to the residents on how the issues were being resolved.	F 244	1. A follow-up to the last 6 months of Resident Council concerns was conducted on 11/4/2015 and reported at Resident Council. 2. All Grievances voiced by the Resident Council were documented and logged for follow-up at following resident council. 3. Activity department was educated on the need to assure all Resident Council concerns are followed up on prior to the next meeting 4. All concerns voiced at Resident Council will be documented and shared with appropriate department for follow-up. The Activity Director will keep a copy of the concerns and assure they are addressed before the next Resident Council meeting. The Activity Director will ask if the solution(s) were satisfactory at this meeting as well. 5. Minutes from Resident Council to include concerns will be reviewed each month at the QAPI meeting to assure the concerns have been followed up on satisfactorily. This will be an ongoing process.	11/27/15
F 253	483.15(h)(2) HOUSEKEEPING &	F 253		

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F 253 SS=E	Continued From page 15 MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe and sanitary environment for 4 of 5 resident areas (East, South, West, Rapid Recovery). The findings were: 1. Observation of the East unit beginning on 10/21/15 at 3:09 PM showed the following maintenance and housekeeping issues: a. The blue chair in front of resident rooms 101 and 100 was stained and soiled with crumbs on the seat. b. The pink chair in front of resident rooms 122 and 123 had various light and dark colored stains on the seat. c. The blue chair in front of resident rooms 112 and 114 had cracks in the vinyl on the seat next to the arm rests, exposing the foam stuffing and creating an uncleanable surface. d. The white chair in front of resident rooms 110 and 111 had cracks in the vinyl on the seat next to the arm rests, exposing the foam stuffing and creating an uncleanable surface. e. The green chair in front of resident rooms 124 and 125 had various soiled areas that were hard and crusty to the touch. f. The pink floral chair in front of resident room 110 had multiple holes in the seat fabric, exposing the foam stuffing and creating an uncleanable surface.	F 253	F253 1. All furniture identified has been either cleaned as needed or destroyed if in ill-repair. The sink in room 6 has been repaired. The shower drain has been repaired. 2. A visual inspection of other resident furniture was conducted; all additional furniture identified has either been cleaned as needed or destroyed if in ill-repair. Flooring in need of repaired has been reviewed and inquiry to state office for approval of bids for new flooring obtained. 3. The Maintenance staff and Housekeeping staff have been educated in the need to remove furniture as needed and address areas of repair promptly. 4. Visual audits will be conducted by Leadership staff 3x weekly for 90 days to ensure furniture and areas of repair are addressed. These findings will be reported to the Maintenance staff and Housekeeping director. 5. The Maintenance and Housekeeping Directors will report findings to the QAPI monthly for a total of 3 months for recommendations, changes, and continuance.	11/27/15

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F 253	F 253 . Continued From page 16 g. The green recliner next to the television in the common room had multiple stains on the arms and seat, crumbs on the seat, and a piece of chewed gum stuck under the left arm rest. h. The drain on the floor of the shower room was loose and exposed three broken 2 inch by 2 inch tiles. i. The carpeting throughout the hallways in this unit was stained and soiled with general discoloration and large and small stained areas. Further, there were crumbs and small bits of debris on the hallway carpet throughout the unit. 2. Observation of the Occupational Therapy (OT) gym in the Rapid Recovery unit on 10/21/15 at 12:35 PM showed a 21 inch by 24 inch area of carpet inside the door which was pulling away from the floor. Interview with the director of rehabilitation at that time revealed the area of carpet had "the potential for someone to trip." 3. Observation of the South unit showed the following maintenance and housekeeping issues from 10/19/15 through 10/22/15: a. Two resident recliners located across from the nurses station were in poor condition with tears in the upholstery and the backing of the chairs coming apart. b. The carpeting throughout the hallways in this unit was stained and soiled with general discoloration and large and small stained areas. c. The threshold of the floor between the clean linen closet and the hallway was missing. This exposed a surface which was not cleanable. d. The bathroom sink in resident room 6 was loose and hanging from the wall with a 1/2 inch gap. 4. Observation in the West unit on 10/20/15 at	F 253		

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F 253	Continued From page 17 10:35 AM showed there was 1 red recliner and 1 blue recliner in the common room that had stains on the fabric that were yellow and brown in color. Further observation at that time showed 3 white sofas with flower pattern that had dirt and debris noted in the seams, discoloration of the fabric, and tears to the seating areas. Observation on 10/22/15 at 12:34 PM showed the green recliner to the far left of the TV in the common room was soiled with dark areas hard and crusty to the touch. 5. Interview with the maintenance director on 10/22/15 at 2:20 PM revealed the damaged chairs in the South unit "needed to be thrown away." He confirmed the sink in resident room 6 was loose and needed to be secured to the wall and caulked. He further confirmed the East shower room drain was loose and needed to be fixed. Additionally, he revealed the carpets in the South and East units were at least 10 years old and it was difficult to remove the stains with deep cleaning. Further, he stated there was a plan to replace the carpet in the OT gym, and the West unit was going to be remodeled; however, there was no set time frame for when the repairs would be completed. 6. Interview with the housekeeping director on 10/22/15 at 3 PM confirmed the identified chairs were stained and due for cleaning. She added she was unsure when the chairs were cleaned last. She further revealed it was the janitor's duty to clean the chairs in common areas and vacuum the hallways, and the night janitor usually cleans 2-3 chairs each night. Additionally, she confirmed the hallway floors and chairs were not cleaned on 10/21/15 as no janitor worked the day shift on that date. Further, she stated the hallway carpets	F 253		

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F 253	Continued From page 18 get deep cleaned once a year and it was difficult to remove all the stains.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a care plan was developed related to a surgical wound treatment for 1 of 1 sample residents (#159) with surgical wounds. The findings were: Review of the "comprehensive evaluation of skin inspection and risk factors" showed it was dated 7/28/15 the same date resident #159 was	F 279	F279 1. Resident #159 no longer resides within the facility. 2. All current and new residents have been reviewed for a current and comprehensive care plan. 3. Nursing staff have received education about initiating an interim plan of care for newly admitted residents, residents with a change of condition and as needed. 4. Random audits will be conducted by DON/Designee 3x week for 90 days on various units to ensure that newly admitted residents have an interim plan of care and that resident requiring changes of current care plan are done so promptly. 5. The DON/Designee will report findings to the QAPI monthly for a total of 3 months for recommendations, changes, and continuance.	

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F 279	Continued From page 19 admitted to the facility. The evaluation showed the resident had a "Jackson-Pratt drainage tube. Review of the "late entry" 7/28/15 nurse's note timed at 8:13 PM showed the resident was admitted from the hospital due to a fall, UTI, Orthostatic hypotension with recent abdominal plasty." The resident was discharged on 7/31/15. The following concerns were identified: a. Review of the "resident room careplan" showed it was dated 7/31/15. There was nothing mentioned on this care plan related to the drain or the wound. b. Interview with the administrator on 10/30/15 at 8:15 AM verified she was unable to find any additional care plan for the resident. Further, she verified there were no physician orders or treatment record available in the resident record related to the drainage tube or the incision site.	F 279		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure staff followed the care plan for 3 of 24 sample residents (#68, #137, #151) and 2 non-sample residents (#24, #51). The findings were: 1. Review of the mobility/fall prevention care plan for resident #51 showed the resident was high	F282	1. Residents' #68, #137, #151, #24, #51 care plans have been reviewed with direct care staff. 2. All residents care plans have been reviewed with direct care staff including updates and changes. 3. All Direct care staff have been educated on the need to review and follow the residents' care plan. 4. The DON/Designee will complete Visual audits 3 x weekly on various units at various times x 90 days to assure resident care plans are being followed. 5. The DON/Designee will report findings to the QAPI monthly for a total of 3 months for recommendations, changes, and continuance.	F 282 11/27/15

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risk for falls due to requiring assistance with transferring from sitting to standing, unsteady balance while standing, and a history of multiple falls. Review of the interventions showed on 3/14/15 an intervention was added to not leave the resident alone while on the toilet. The following concerns were identified:

a. Review of the 9/29/15 incident/fall progress note timed at 7:56 PM showed the resident had an unwitnessed fall in the bathroom while attempting to self transfer. The resident did not have any signs of injury and skin was intact. The note further showed the CNA who left the resident alone was educated regarding the resident's safety needs.

b. Interview with the DON on 10/22/15 at 1:07 PM verified the interventions to prevent falls were expected to be followed.

2. Review of the 9/12/14 care plan/interventions for mobility/fall prevention showed resident #24 had falls in the past and required assistance to ambulate. The staff were to provide 1 to 1 supervision with the resident when using the bathroom to ensure s/he doesn't attempt to transfer with out assistance. The interventions further showed on "3/23/15 staff will be educated to take the resident to the bathroom when s/he requests." This was the latest date for the fall interventions on the care plan. The following concerns were identified:

a. Review of the 10/19/15 incident/fall progress note timed at 12:35 PM showed the resident had an unwitnessed fall in the bathroom while attempting to self transfer. The resident did not have any signs of injury and skin was intact and there was no redness. The note further showed the employee was new and left the resident alone to answer another call light. The

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CNA was educated regarding the resident's safety needs.

b. Interview with the DON on 10/22/15 at 1:07 PM verified the care plan interventions to prevent falls were expected to be followed.

3. Observation on 10/20/15 at 10:30 AM showed resident #137 was sitting in the common area in a wheelchair watching television and looking at the newspaper. The resident self-propelled to the dining room. The sweatshirt the resident wore appeared discolored with brown spots. During a conversation at 11:10 AM the resident stated the sweatshirt was "dirty" and further indicated s/he liked clean clothing.

Continued observation showed the resident ate the noon meal. Following the meal, the resident left the dining room at 12:45 PM and returned to the common area to watch television. At 1:15 PM the resident was assisted to the activities area to play cards until 2:50 PM then taken by staff to watch television. The resident was taken to his/her room to be placed on oxygen while the portable tank was filled. At that time the resident was toileted. CNA #3 assisted the resident to the toilet. The resident was incontinent of urine.

Review of the care plan for hygiene, activities of daily living and skin last revised on 4/28/14 showed the agency staff was to "change clothing when soiled to ensure clean, neat appearance per preference." Further, the care plan showed for bowel and bladder function, last revised on 4/7/15, the resident was to be offered/toileted every morning, before and after meals and at night and as needed.

4. Review of the MDS assessment dated 9/3/15 for resident #68 showed diagnoses that included

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Alzheimer's disease, muscular atrophy, and non-Alzheimer's dementia. Continued review showed the resident required extensive assistance of 2 or more persons for transfers and total assistance of 1 person for toilet use and personal hygiene. Review of the care plan for skin revised on 8/8/12 showed the resident was at risk for skin breakdown due to incontinence of bowel and bladder and interventions included staff to provide cares as ordered. Review of the care plan for bowel and bladder function revised on 8/10/12 showed the resident was unable to alert staff when help was needed to use the bathroom and interventions included checking for incontinence every AM, before meals, after meals, at bedtime, and as needed. The following concerns were identified:

a. Continuous observation on 10/20/15 from 9:06 AM to 1:15 PM showed the resident was in his/her wheelchair, with lap belt applied, and was not offered to toilet or checked for incontinence for 4 hours and 9 minutes.

b. Observation of care on 10/20/15 at 1:15 PM showed 2 staff members assisted the resident to transfer to bed and checked the resident for incontinence. CNAs #4 and #5 confirmed the resident was incontinent of bowel and bladder at that time.

5. Review of the 10/4/15 quarterly MDS assessment showed resident #151 had diagnoses that included muscle weakness, failure to thrive, weight loss, and hypertonicity of the bladder. Further review showed the resident had a BIMS score of 3/15 (severe cognitive impairment) and required extensive assistance for transfers and toileting. Review of the care plan for "nutritional status" created on 9/28/15 showed the resident required cueing and assist at meals

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as needed. Review of the care plan addressing incontinence, created on 9/5/12, showed the resident was incontinent and required 1-2 person assist with toileting, including before and after meals. The following concerns were identified:

a. Continued observation on 10/20/15 beginning at 10:25 AM showed the resident sitting in the wheelchair in the common area. At 11:17 AM, CNA #6 wheeled the resident into the dining room, without offering to toilet the resident or checking for incontinence.

b. At 11:49 AM, the resident was served a meal of a shredded chicken over rice, with mixed vegetables, a jello dessert, and a brownie. The resident also had a cup of water next to the plate. The resident was observed to eat the brownie and approximately 20% of the rice and chicken during the meal. The cup of water appeared untouched. During the meal, the resident was not provided cueing or offered assistance with eating.

c. At 12:04 PM the resident was assisted out of the dining room by a dietary aide into the hallway. At 12:20 PM, CNAs #2 and #3 assisted the resident into his/her room and into bed under a blanket, without offering to toilet the resident or checking for incontinence. At that time the surveyor requested they check for incontinence. The CNAs changed the resident's brief and confirmed the resident had been incontinent of bowel and bladder.

6. Interview with the DON on 10/22/15 at 10:45 AM revealed residents should be toileted when gotten up, before meals, after meals, at bed time, and as needed. Further interview revealed the facility wanted residents to be repositioned at least every 2 hours to maintain skin integrity.

7. Review of the policy titled "Repositioning"

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F 282	Continued From page 24 revised in April 2014 showed "...repositioning the resident in the chair 1. Encourage the chair-bound resident, who is able to move, to change positions or shift weight every fifteen minutes, or as often as possible...4. Assist the resident to change his or her position in the chair. Monitor the need for toileting or incontinence care when changing position."	F 282		
F 309 SS=E	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 medical record review and staff interview, the facility failed to ensure the services provided maintained the highest practicable physical well-being for 4 of 22 sample residents with pain (#3, #54, #105, #141). The findings were: 1. Review of the care plan for pain showed resident #141 had diagnoses to include anxiety, chronic obstructive pulmonary disease and neurofibromatosis (genetic disorder that affects the cell growth of neural tissue). Further, the care plan showed for pain, last revised on 4/28/14, the resident's acceptable pain level was 4 to 5 and it showed the resident "would like to experience pain relief within 30 minutes of receiving pain	F 309	F309 1. Residents#3, #54, #105, #141 have been assessed for pain, pain care plans reviewed and pain efficacy reviewed for effectiveness. 2. All residents have assessed for pain, pain care plans reviewed and pain efficacy reviewed for effectiveness. 3. Education has been provided to nursing staff to ensure that residents' pain regimen, pain care plans are followed and pain efficacy is assessed within 60 min of administration. 4. The DON/Designee will conduct audits on various units at various times of the EMAR for residents with a pain regimen at least 3x a week for 90 days. 5. The DON/Designee will report findings to the QAPI monthly for a total of 3 months for recommendations, changes, and continuance. 11/27/15 jc	

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medication and/or non-pharmacological intervention." Staff were to encourage the resident to report the onset of pain, identify its location and rate the intensity of pain. The staff were to evaluate the effectiveness of the pain medication within 30 minutes of administration. The following concerns were identified:

a. Review of the medication administration record for October 2015 showed the resident received the combination pain medication hydrocodone 5 mg (milligrams)-acetaminophen 325 mg 20 of 21 days as needed for pain (39 doses). Further review showed the resident's pain level was rated on a scale of 0 to 10 with 10 being the worst pain prior to each administration. Post pain assessments only showed the medication was effective. In addition, the medication benadryl was given 19 of 21 days, at approximately the same frequency as the pain medication (32 doses). Benadryl was prescribed for itching and consistently given with the pain medication.

b. Review of the nurses' notes for October 2015 showed the post-pain assessments were completed up to 3 hours and 41 minutes after medication administration. There were no assessments completed within the 30 minute time frame. Further, the nurses' notes only showed the medications were given. There was no documentation to show the location of the pain/itching. Further, there was no indication non-pharmacological interventions were provided.

c. During an interview with the DON on 10/22/15 at 3:30 PM, she verified the nursing staff needed to assess the resident following the pain medication administration using the same pain scale used prior to administration. Further, she indicated non-pharmacological interventions needed to be attempted for pain.

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F 309	Continued From page 28 2. Review of the 6/9/15 revised comfort/pain care plan showed resident #105 had pain related to a cerebralvascular accident with left sided weakness, and a pressure ulcer to the right calf with a surgical debridement. The goal for the resident's pain was to keep the pain between a pain score of 1 - 4. Review of the 10/3/15 nurse's note timed 5:46 AM showed the resident no longer had dressing changes, and the order for hydrocodone-acetaminophen 5-325 mg 1 tablet to be given prior to dressing changes was discontinued. Review of the October 2015 MAR showed the resident continued to have an order for Tylenol 325 mg 2 tablets every 4 hours as needed (PRN) for pain. The orders also showed Tylenol 325 mg 2 tablets every 6 hours PRN. The following concerns were identified: a. Review of the nursing notes showed on 9/18/15 at 9:11 PM the resident was administered 2 tablets of the Tylenol for complaints of joint pain. The effectiveness of the pain medication was assessed at 12:20 AM, 3 hours and 9 minutes later, which showed the resident was sleeping. b. Review of the nursing notes showed on 10/10/15 at 9:29 PM the resident was administered 2 tablets of the Tylenol for complaints of joint pain with a pain rating of 4/10. The effectiveness of the pain medication was assessed 2 hours and 5 minutes later at 11:34 PM, which showed the resident was sleeping. c. Review of the nursing notes showed on 10/15/15 at 3:14 PM the resident was administered 2 tablets of the Tylenol for complaints of pain to hips back and legs. The effectiveness of the pain medication was assessed at 6:08 PM, 2 hours and 54 minutes later, which showed the medication was "effective."	F 309		

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3. Review of the quarterly MDS assessment dated 9/3/15 showed resident #54 had diagnoses that included manic depression and signs and symptoms of involuntary nerve involving the musculoskeletal system and was unable to answer questions about pain presence. The staff assessment for pain was not completed. Review of the physician's orders for October 2015 showed the resident had an order for Acetaminophen 325 mg 1 to 2 tabs by mouth every 4 hours for pain or fever as needed (PRN). The following concerns were identified:

a. Review of the "Pain Assessment" dated 9/2/15 showed a pain assessment interview should be conducted. The resident was unable to answer related to pain presence, pain frequency, and pain effect on function. The frequency of indicators of pain or possible pain was not assessed.

b. Review of the October 2015 MAR showed pain assessments ordered every shift were not completed prior to 10/20/2015. Further review showed 2 tablets of Acetaminophen were administered on 10/10/15 at 8:52 AM and pain was not assessed prior to administration nor was the effectiveness of the medication assessed after medication administration.

4. Review of the 9/3/15 quarterly MDS assessment showed resident #3 had diagnoses that included pain in joint and colostomy. Review of the "Comfort/ Pain" care plan revised on 4/28/15 revealed the resident wanted "to use non-pharmacological treatments before increasing my pain medication." Further review showed the non-pharmacological treatments included "apply heat, apply ice, rub the affected area, reposition, apply pillows." The care plan

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F 309	Continued From page 28 also indicated the resident wished to "keep my pain between a pain score of 1-4." Review of the active orders showed the resident had orders for acetaminophen 500 mg 1-2 tablets as needed for pain and ibuprofen 600 mg as needed for pain. The following concerns were noted: a. Review of the October 2015 MAR showed the resident received acetaminophen 26 times between the dates 10/1/15-10/21/15. There was no evidence in the chart that indicated whether the resident was administered 1 or 2 tablets, the location of the pain, what the resident's pain level was at the time of administration, or if non-pharmacological approaches were attempted prior to administering the medication. There was no evidence of what the resident's pain level was after receiving the medication. b. Review of the October 2015 MAR showed the resident received ibuprofen 22 times between the dates 10/1/15-10/21/15. There was no evidence of the location of the pain, what the resident's pain level was at the time of administration, if non-pharmacological approaches were attempted prior to administering the medication, or what the resident's pain level was after receiving the medication. 5. Interview with the DON on 10/22/15 at 10:45 AM revealed that pain should be assessed every 12 hours and pain levels should be documented on the MAR before and after the administration of PRN medications.	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	F 312		

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F 312	Continued From page 29 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, review of bathing documentation, and medical record review, the facility failed to ensure 7 of 21 sample residents (#54, #56, #68, #82, #105, #121, #140) who were dependant on staff were provided the assistance required for ADLs. The findings were: 1. Review of the 6/9/15 admission MDS assessment showed resident #105 was cognitively intact with a BIMS score of 15, and required extensive assistance for personal hygiene and bathing. Observation on 10/21/15 at 5:30 PM showed the resident was eating in his/her room. The fingernails on both hands were long and caked with a dark colored substance underneath the long nails. Interview with the resident at that time revealed s/he got a shower about once per week. Interview with the South unit manager on 10/21/15 at 6:30 PM verified the resident's nails were dirty and they were being soaked in order to clean them. 2. Observation on 10/20/15 at 10 AM showed resident #140 was taken to the shower in a wheelchair. CNAs #3 and #7 transferred the resident from the wheelchair to the shower chair. CNA #3 washed the resident's anterior perineum and lower extremities with gloved hands. The posterior perineum was not cleansed. After the shower was completed the resident had a bowel movement while in the shower chair. The CNAs assisted the resident to a standing position and	F 312	F312 1. Residents #54, #56, #68, #82, #105, #121, #140 have been assessed for ADL care for dependent care, care plans have been updated. 2. All residents requiring dependent care have been assessed. A shower schedule and log have been established on all units for all residents. 3. All direct care staff have been educated on required cares for dependent residents. All direct care staff have been educated on showering and nail care procedures to ensure that all residents hygiene needs are met. Including Pedicare. 4. Visual audits will be conducted by the leadership team on general hygiene and nail care 3x week for 90 days, reporting findings to the DON/Designee. DON/Designee will conduct random audits during showers for dependent care residents at least 3x weekly for 90 days. 5. The DON/Designee will report findings to the QAPI monthly for a total of 3 months for recommendations, changes, and continuance.	11/27/15

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placed an incontinence pad on the resident. The CNAs did not cleanse the anterior/posterior perineum following the bowel movement. The resident was transferred to the wheelchair and taken to the common area. Review of the 10/4/15 quarterly MDS assessment showed the resident required total assistance with toileting and transfers. In addition, the resident required extensive assistance with personal hygiene.

3. Review of the quarterly MDS assessment dated 9/3/15 showed resident #54 had diagnoses that included manic depression and "signs and symptoms of involuntary nerve involving the musculoskeletal system." Further review showed the resident required total assistance of 1 person for personal hygiene and total assistance of 2 or more persons for bathing. Review the facility shower records for October and September 2015 showed the resident received a shower on 10/5/15 and the next documented shower was dated 9 days later on 10/14/15. There were no documented showers after 10/14/15. Further review showed the facility had no documentation of showers for the resident prior to 9/27/15.

4. Review the facility shower records for October and September 2015 showed sample residents #56, #68, #82, #121 who resided on the West unit did not have bathing documentation available to show when they were bathed/showered prior to 9/27/15 or after 10/14/15.

5. Interview with the DON on 10/22/15 at 10:46 AM revealed residents should receive showers at least 1 time per week.

6. Interview with the administrator on 10/21/15 at 2 PM revealed the facility did not have a tracking

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F 312	Continued From page 31 system for resident showers. Shower logs were located in each shower room with a list of residents assigned to those rooms. If the aides took the residents to a shower room other than where they were assigned, the showers would not get logged. Further, she acknowledged it was not a good system for tracking and ensuring residents received their scheduled showers.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and policy and procedure review the facility failed to ensure prevention measures were implemented for 2 of 20 sample residents (#68, #137) who were at risk for developing pressure ulcers. The findings were: 1. Review of the MDS assessment dated 9/3/15 for resident #68 showed diagnoses that included Alzheimer's disease, muscular atrophy, and non-Alzheimer's dementia. Continued review showed the resident required extensive assistance of 2 or more persons for transfers and was at risk for skin breakdown. Review of the	F 314	F314 1. Residents #64 and #137 have been assessed for positioning and skin integrity. 2. All residents requiring assistance with repositioning or with high risk of skin breakdown will be reassessed, as indicated residents will be provided with pressure redistribution devices and appropriate updates to the care plan. 3. Education was provided to all staff on resident repositioning. 4. Visual audits will be conducted by the Leadership team 3 x weekly on various units at various times x 90 days to assure repositioning is occurring per care plan, reporting to the DON/Designee. 5. The DON/Designee will report findings to the QAPI monthly for a total of 3 months for recommendations, changes, and continuance.	11/27/15