Part 1

This was split into two parts because of size

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

PRINTED: 01/29/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535024	A. BUILDING _____ B. WING _____	C 01/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4305 S POPLAR CASPER, WY 82601

(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 1/11/16 through 1/15/16. The survey was prompted by complaint intakes WY00002176, WY00002174, WY00002165, WY00002164, WY00002159, WY00002157, WY00002153, WY00002152, WY00002146, WY00002145, WY00002142, WY00002132, WY00002125, WY00002115, WY00002114, WY00002112, WY00002105, WY00002087, WY00002050, and WY00002044 The following common abbreviations are used throughout this document: ADLs- Activities of daily living ADON- Assistant director of nursing CAA- Care area assessment CNA- Certified nurse aide DON- Director of nursing services MAR- Medication administration record MDS- Minimum Data Set LPN- Licensed practical nurse RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F-156: Notice of Rights, Rules, Services, Charges Corrective Action: and Sheet The Medicare and Medicaid required information has been placed in the front area of the facility. Identification of Others: There is no other required documentation or information that is not displayed for CMS. Systemic Changes: The Administrator or Designee will check monthly for the posting of the Medicare and Medicaid required information and ensure it is located in an area easily accessible by visitors, staff, and residents. Monitoring: The QAPI Committee will evaluate	2/23/16
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Admin — (X5) DATE: 2/8/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

RECEIVED
WY Dept of Health
FEB 08 2016
Healthcare Licensing and Surveys

DOC accepted. Call to Doug Jansen, WDH 2/18/16 @ 11:26 a.m.

Additional Concern Call 10 NLC Change pg. 68/71 for DOC Tony called on 2/19/16. Jennifer Dunn

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F 156	Continued From page 1 §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(I)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community	F 156	effectiveness of the systemic changes based on additional interventions as needed to ensure compliance then reassess the need for continued monitoring based on compliance until resolved.	

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F 156	Continued From page 2 spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure written information regarding Medicare and Medicaid benefits and contact information for the State survey agency	F 156		

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F 156	Continued From page 3 were prominently displayed. The census was 111. The findings were: Observation on 1/12/16 at 10:30 AM showed no evidence of posted contact information for the State survey agency. Additionally, information regarding Medicare and Medicaid benefits was not on display. Interview with the administrator on 1/15/16 at 4:40 PM verified the information was not posted.	F 156	F-157: Notify of Changes (Injury/Decline/Room, etc.) It is the practice of the facility to inform the resident; consult with the resident's physician and if known, notify the resident's legal representative or an interested family member when there is a significant change of resident's physical, mental, or psychosocial status.	2/23/16
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157	**Corrective Action** Resident #116 no longer resides at the facility. The physician has reviewed finger stick blood sugar results and insulin orders for resident #20. Wound treatment orders for resident #52 have been reviewed and updated. Resident #85 was seen by the physician and soft area behind his knee was assessed by the physician. **Identification of Others** An audit will be completed by Director of Nursing / designee, to identify any residents with an acute change of condition within the last 30 days to ensure that the resident's physician and	

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F 157	Continued From page 4 this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to consult with the resident's physician after a change in condition for 4 of 7 sample residents (#20, #52, #85, #116) with a change in condition. This failure resulted in harm to residents (#20, #116). The findings were: 1. Review of the 5/12/15 interdisciplinary team note showed resident #116 was admitted to the facility for rehabilitation after lumbar surgery, and infection of the surgical wound. The following concerns were identified: a. Review of the nursing note dated 5/27/15 and untimed showed "Resident crying out this am, very drowsy from pain meds [medications] earlier & flexeril [a muscle relaxant], c/o [complains of] that [s/he] couldn't feel [his/her] legs, difficulty sitting up @ [at] bedside, very adamant that [s/he] wanted to lay in bed..." b. Review of the 5/28/15, untimed, late entry for 5/27/15 nursing note showed "Request to get resident in to see [physician name] @ [clinic name] d/t [due to] increased pain and difficulty moving [his/her] legs. [S/he] was rescheduled with an appt. [appointment] for 29th. Incision noted to be without s/sx [signs/symptoms] infection and resident was ext X 1 asst [extensive assist of 1 person] with transfer to recliner with nurse." c. Further review of the medical record	F 157	legal representative was notified of the change, orders obtained and written as needed and care plan updated when needed. Corrective actions will be taken as needed. An audit has been completed by Director of Nursing / designee, to identify any residents that are diabetic and have finger stick blood sugar orders and or insulin orders.. The audit includes checking for parameters for physician notification of blood sugar results and notification of physician of results outside of the parameters and insulin administration per orders. Corrective actions will be taken as needed. An audit will be completed by Director of Nursing or designee of medication and treatment administration records for the past 2 weeks to identify any instances where medication or treatment was not provided due to pattern of resident refusal or supplies not being available. The audit will also include checking that vital signs are completed as needed and that any parameters for medication administration are followed. Corrective actions will be taken as needed including physician notification.	

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F 157	Continued From page 6 showed no evidence the physician was contacted directly about the resident's increased pain and inability to feel his/her legs. d. Review of the 5/29/15 nurse's note timed at 11:50 PM indicated the resident had an appointment at the clinic, and returned with new orders. Notes from this appointment were requested from the facility, and were not available. e. Review of the 5/31/15 "SBAR Communication Form and Progress Note" timed at 9 PM showed "Increased lumbar pain unrelieved by medications, no feeling in either leg. Demands to go to [clinic name] for eval [evaluation] by [his/her] surgeon [physician name]..." The note further showed the resident was transferred to the hospital via non-emergent ambulance, and subsequently taken to a Denver, Colorado hospital via emergency air transport. f. Review of the 6/1/15, untimed, nurse's note showed the resident was sent to a Denver hospital related to "L4 & L5 [lumbar vertebrae] disintegrating due to infection." g. Interview with the DON, ADON and corporate nurse on 1/16/16 beginning at 2:05 PM confirmed the facility could provide no evidence the resident's physician was consulted about the change in condition on 5/27/15. 2. Review of the medical record showed resident #20 required daily medication for Diabetes Mellitus. Review of the January 2016 medication review form showed the physician ordered blood sugar levels before meals and at bedtime and sliding scale insulin based on the results of the blood sugar levels, Lantus insulin 40 units at bedtime, and Metformin 500 mg pills twice daily. Further review of the medication review form showed the parameters for the sliding scale	F 157	**Systemic Changes** The DON or designee will educate the licensed nursing staff, on or before date of compliance, regarding the notification of the physician and resident's legal representative any acute changes in condition and noting this notification in the medical record. The education will include physician notification of patterns of refusals of medication or treatment, physician notification when supplies or medications are not available and obtaining alternative orders until supplies or medications are available and following parameters on physician orders and obtaining vital signs as needed.. The education will also include obtaining parameters for physician notification of finger stick blood sugar results, notification of physician when blood sugar results are outside of the parameters, and following physician orders for insulin. The Director of Nursing or designee will review incident / accident reports, 24 hour report and the clinical dashboard in Point Click Care in morning meeting daily Monday or Friday to identify any resident change of condition. Documentation will be reviewed for physician notification for identified change of condition.	

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F 157	Continued From page 6 insulin administration addressed blood sugar levels up to 350 (this number is milligrams of glucose per deciliter of blood), but failed to address blood sugar levels above 350. The following concerns were identified: a. Review of the January 2016 MAR showed the resident did not receive the sliding scale insulin dose and/or staff did not check the resident's glucose level at various times from 1/4/16 to 1/9/16 because s/he refused. This review showed the resident did not receive the sliding scale insulin for the following documented blood sugar levels: 464 at 1 PM and 387 at 9 PM on 1/4/16; 572 at 1 PM and 472 at 5 PM on 1/5/16; 486 at 1 PM on 1/6/16; 499 at 5 PM on 1/7/16; and 499 at 9 AM on 1/8/16. b. Review of the nursing progress notes and documented communication with the physician showed staff did not report their inability to obtain the blood sugar levels as ordered, elevated blood sugar levels above 350, and omitted insulin doses to the physician. c. Interview with the DON on 1/11/16 at 2:05 PM revealed the resident was transported to the hospital on 1/10/16 and his/her blood sugar level was 800. Interview with the ADON on 1/14/16 at 8:45 AM revealed staff should have reported the elevated blood sugar levels and lack of insulin administration to the physician. He further stated the physician's order for sliding scale insulin was unclear regarding levels above 350, and the nurses should have clarified the order. 3. Review of the 11/12/15 admission MDS assessment showed resident #52 was admitted with a surgical wound, and was receiving surgical wound care. Further, the resident required the extensive assistance of 2 or more persons for most ADLs. Review of the resident's care plan for	F 157	~~The Director of Nursing or designee will~~ review Change of Conditions daily Monday – Friday for 2 weeks and then review 5 Change of Conditions weekly for 2 months to check that physician and resident's legal representative member was notified of change. The audit will also will also include documentation, review of new orders, appropriate interventions, and care plan. If concerns are identified corrective action will be taken based on findings. The Director of Nursing or designee will audit finger stick blood sugar orders and results and insulin administration weekly for 1 month for correct administration and physician notification of results outside of parameters. After 1 month, random audit of 3-5 finger stick blood sugar results and follow up will be completed weekly for 2 months. Corrective actions will be taken as needed based on findings. The Director of Nursing or designee will complete an audit of medication and treatment records weekly for 1 month and then a random audit of 25% of records weekly for 2 months for patterns of refusals, unavailability of supplies or medications and physician notification and obtaining vital signs as ordered and	

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F 157	Continued From page 7 skin issues showed an intervention dated 11/16/15, "Observe wound healing and maintain wound vac [vacuum] as dressing..." Review of physician orders showed a 12/24/16 order for "Wound vac to R [right] buttock wound. Wound vac maintenance daily with dressing change on MON [Monday], WED [Wednesday] and FRI [Friday] every day and night shift..." The following concerns were identified: a. Review of the 12/27/15 late entry for 12/26/15 progress note showed "...was going to change wound vac to right buttock area, no wound canisters were found..." b. Review of the 12/27/15, timed 6:27 PM, progress noted showed "wound continues to be without wound vac..." c. Further review of the medical record showed the order for the wound vac was not discontinued until 12/30/15. d. Interview with the DON, ADON and corporate RN on 1/15/16 beginning at 2:05 PM confirmed the resident's wound vac was not changed according to the physician's orders because the facility did not have the needed supplies. Further, the DON confirmed the physician was not contacted regarding the facility's inability to apply the wound vac until 12/30/15. 4. Review of the 1/6/16 quarterly MDS assessment showed resident #85 had diagnoses that included chronic pulmonary embolism and deep vein thrombosis in the lower left leg. Review of the SBAR (situation, background, assessment, recommendation) form dated 12/20/15 showed the resident complained of increased discomfort to the left lower extremity. A "soft raised area behind left knee" was also identified by the nurse completing the assessment. Further review of the	F 157	~~administering medication per physician~~ orders. Corrective actions will be taken as needed based on findings. **Monitoring** The Director of Nursing will report the findings to the QAPI Committee to evaluate the effectiveness of the systemic changes and implement additional interventions as needed to ensure compliance and then reassess the need for continued monitoring based on compliance until resolved.	

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F 157	Continued From page 8 SBAR form showed an area to indicate the date and time the physician was notified; however, this area was left blank. Interview with the DON, ADON, and corporate RN on 1/15/16 at 2:15 PM confirmed the SBAR form did not indicate the physician was notified of the resident's complaint. Interview with the DON on 1/15/16 at 8 PM verified there was no additional documentation to show the physician was notified.	F 157	~~F 166: Right to Prompt Efforts to~~ Resolve Grievances **Corrective Actions:** The grievances for G7, G8, G10, G11, G17, G21, and G26 have been investigated as allegations of abuse/neglect or mistreatment and a report of each sent to the OHLS. The grievances for G1, G2, G3, G4, G9, G12, G16, G18, G20, G23, G24, G25, G27, G28, G29, G30, and G31 have had a resolution or have had adequate information to determine resolution and follow up made by the Administrator or Designee. Review of the corrected grievances has been completed by the Administrator. **Identification of Others:** The Customer Service Director (CSD) has done a review of the Concern Forms from December 1st to January 31st for compliance. Concern forms not in compliance or without resolution have been remedied. **System Change:** The facility staff has been educated on the TLC and Concern process by the CSD.	2/23/16
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of concern form information, and review of policy and procedure, the facility failed to ensure 32 of 47 grievances lodged in December 2015 and January 2016 were reasonably responded to and/or resolved. The findings were: Review of the "Truly Listening to Our Customers (TLC) Program" with a revised date of June 2013 showed the process by which concerns were addressed. When staff received a concern, they should acknowledge receipt of the concern and immediately address the concern if possible and document the resolution. "a. If the concern relates to nursing care or alleged abuse, neglect, and/or mistreatment, the concerns should be forwarded immediately to the supervisor or the administrator/Director of Nursing for follow-up...b.	F 166		

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F 166	Continued From page 9 All other concerns must be forwarded to the administrator within 24 hours of receipt or on the first business day following receipt..." The program also showed during the morning interdisciplinary team meeting, all concerns were discussed with department managers. A person was designated and will have 3 days to investigate and document the conclusions. The investigation report will be forwarded to the administrator by the third day after receipt. "3. Within 24 hours the Administrator will review the findings with the person investigating the concern to determine if it has been resolved...The Administrator and/or department manager will contact the resident or person filing the concern as soon as possible but not longer than within 72 hours of receipt of the concern to alert them that the concern has been resolved." The following concerns were identified with grievances (number G1-G32) these represented 24 residents: a. Seven grievances (G7, G8, G10, G11, G17, G21, G26) were not referred for investigation as allegations of abuse/neglect or mistreatment. b. Eighteen grievances (G1, G2, G3, G4, G9, G12, G16, G18, G19, G20, G23, G24, G25, G27, G28, G29, G30, G31) were not resolved or did not contain adequate information to determine resolution. Further, 13 of these grievances (G1, G3, G4, G5, G8, G13, G14, G15, G19, G22, G23, G26, G29) showed no follow-up was made to the resident or person filing the concern. c. Of the 32 unresolved grievances, 2 (G23, G10) showed the administrator had reviewed them. The remainder showed the area to be signed and the "date the administrator followed up with individual" was blank.	F 166	Concern Forms regarding Nursing Care or alleged abuse, neglect, and/or mistreatment will be forwarded immediately to the Supervisor or the Administrator/Director of Nursing for investigation and reporting when necessary. The Concerns will be brought to the IDT then forwarded to the appropriate individual for resolution, completion, and follow up per the TLC program. The Administrator and/or CSD will review the Concern Form log and Concern Forms once per week to ensure compliance. Non-compliant Concern Forms will be returned timely to the appropriate individual for completion. **Monitoring:** The QAPI Committee will evaluate effectiveness of the systemic changes based on additional interventions as needed to ensure compliance then reassess the need for continued monitoring based on compliance until resolved	

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PRINTED: 01/29/2016
FORM APPROVED
OMB NO. 0938-0391

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F 166	Continued From page 10 d. Interview with the corporate RN and the DON on 1/15/16 at 4:30 PM verified the resolution to some grievances needed to be better. Further, they verified concerns with allegations of abuse and neglect had not been well-assigned, had not been reported, and may not have been adequately investigated. e. Interview with the administrator on 1/15/16 at 5:35 PM revealed the process related to concern resolution was in need of more monitoring.	F 166		
F 167 SS=B	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the most recent survey results were available and accessible to all residents in the facility for review. The census was 111. The findings were: Observation on 1/12/16 at 11:30 AM showed a notebook containing state survey results was posted next to the front door in a sitting area. The notebook was located approximately 5 feet off the	F 167	**F-167: Right To Survey Results-Readily Accessible** **Corrective Action:** The binder containing past survey results has had the 11/6/15 survey results added and the bin it is in has been lowered to ensure access. **Identification of Others:** There are no other areas affected. **Systemic Changes:** The Administrator or Designee will check monthly for accessibility and completeness of the Survey Results Binder. **Monitoring:** The QAPI Committee will evaluate effectiveness of the systemic changes based on additional interventions as needed to ensure compliance then reassess the need for continued monitoring based on compliance until resolved	2/23/16 TC

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F 167	Continued From page 11 floor with an armchair below it, putting it out of reach for residents in wheelchairs. Additionally, the most recent health survey found in the notebook was from the 7/23/15 complaint survey. The 11/6/15, 11/18/15, and 12/2/15 complaint surveys were not in the book. Interview with the administrator on 1/15/16 at 11:45 AM confirmed the survey results were not accessible to all residents, and "needed to be lowered." He further confirmed the most recent survey results were not available in the notebook.	F 167		
F 174 SS=E	483.10(k),(l) RIGHT TO TELEPHONE ACCESS WITH PRIVACY §483.10(k) Telephone The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. §483.10(l) Personal Property The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility failed to ensure residents' personal property was available to use. The facility census was 111. The findings were: 1. During a confidential group interview on 1/12/16 at 3 PM of 4 of 13 residents revealed they had clothing lost when sent to the laundry facilities, and the facility had been unable to	F 174	~~F 174: Right To Telephone Access~~ With Privacy **Corrective Action:** Resident #106 had her missing items returned to her the day after they were missing. Resident #30 has had their missing laundry returned or replaced. The bag of unclaimed laundry items was displayed for the residents to go through and claim their missing item. Claimed items were marked and returned to the residents. Residents who have informed us of missing laundry items have had them returned or replaced by the facility. **Identification of Others:** A review of the last 60 days of Concern Forms was completed by the facility CSD for residents who have noted laundry missing for resolution. Residents who have not had their clothing returned have had them found or replaced. **Systemic Changes:** The Facility Staff have been educated on the Performance Improvement Plan (PIP) developed by the Laundry Management.	2/23/16 TG

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F 174	Continued From page 12 locate the missing items. 2. Interview on 1/11/16 at 2:25 PM with resident #106 revealed the facility lost some of his/her clothes when they were sent to laundry and neither s/he nor the facility had been able to locate them. 3. Interview on 1/13/16 at 12:42 PM with resident #30 revealed the facility lost some of his/her clothes when they were sent to laundry after the resident was admitted. 4. Observation on 1/13/16 at 12:30 showed 5 large garbage bags full of clothes stored in a closet in the secure unit. Interview at that time with the laundry district manager revealed the bags contained unclaimed resident clothes. 5. Interview with the laundry manager on 1/15/16 at 12 PM revealed the process for identifying lost clothing was for the residents or family members to search through the bags for their belongings. She revealed the process was not working well and needed to be revised.	F 174	Newly admitted residents will have their clothing bagged and labeled with their names and delivered to the laundry Manager to ensure the articles are labeled per the PIP. The laundry staff will check soiled resident laundry for any unlabeled apparel and separate it so staff can determine its owner. The articles will then be labeled with the residents name to ensure it gets returned properly after laundering. The Laundry Manager or designee will inspect the laundry 4 times per week for unlabeled or unclaimed the owner in a timely manner. Concern Forms will be reviewed and random interviews will be conducted weekly by the Laundry Manager or designee for residents reporting missing laundry items. The concerns will be resolved per the facility TLC program.	
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.	F 203	**Monitoring:** The QAPI Committee will evaluate effectiveness of the systemic changes based on additional interventions as needed to ensure compliance then reassess the need for continued monitoring based on compliance until resolved	

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F 203	Continued From page 13 Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and	F 203	**F-203: Notice Requirements Before Transfer/Discharge** **Corrective Actions:** The resident has been discharged. **Identification of Others:** No other residents have been affected by this. **Systemic Changes:** The facility Management staff has been educated on 42 CFR 483.12 (a) (2) (I, III) by the Administrator. Residents who are being discharged to another facility under 42 CFR 483.12 (a) (2) (I, III) will have notification that complies with the regulation. The Administrator or Designee will monitor any impending discharge of a resident under those circumstances for compliance. **Monitoring:** The QAPI Committee will evaluate effectiveness of the systemic changes based on additional interventions as needed to ensure compliance then reassess the need for continued monitoring based on compliance until resolved	2/23/16 TB

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F 203	Continued From page 14 Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide a discharge notice to 1 of 1 sample residents (#118) with a facility-initiated discharge. The findings were: Review of the 8/26/15 MDS assessment entry tracking record showed resident #118 was re-admitted to the facility from an acute hospital on 8/26/15. Review of the 8/29/15 nurse's note, timed at 11:30 PM, showed the resident had self-injurious behavior, and orders were received from the on-call physician to send the resident to the hospital. Interview with the DON, ADON and regional nurse consultant on 1/15/16 beginning at 2:05 PM revealed the facility declined to take the resident back from the hospital due to concerns about being able to meet the resident's needs. Further review of the medical record showed no evidence a discharge notice was provided to the resident or the resident's family member. Interview with the medical records director on 1/15/16 at 6:10 PM confirmed no discharge notice was provided to the resident or the resident's family.	F 203	F-225: Investigate/Report Allegations/Individuals **Corrective Actions:** The concern forms that revealed issues that required reporting and investigation to rule out abuse/neglect/mistreatment for residents #2, #11, #27, #31, #42, #78, #99, #114, #121 have been reported, investigated and acted on accordingly where necessary. Corrective actions have been taken with staff members accordingly. Resident #68 has had an investigation regarding a fall on 12/20/16 to rule out abuse and a report sent to the OHLS Resident #44 has had an investigation completed regarding allegation of sexual abuse and a report sent to the OHLS. Resident #30 has had an investigation regarding an allegation of neglect and a report sent to the OHLS. **Identification of Others:** A review of Incident/Accident reports and Concern Forms for the past 60 days has been completed by the Administrator, DON, and/or the CSD for issues that required reporting and investigation to rule out abuse/neglect/mistreatment. Issues that	2/23/16
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide	F 225		

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F 225	Continued From page 15 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 medical record review, staff and resident interview, review of concern form information, and review of State survey and certification agency logs, the facility failed to ensure 13 random reportable incidents related to	F 225	were found were investigated and reported to OHLS. **Systemic Changes:** The facility management staff has been educated on abuse/neglect/mistreatment and what is to be reported and investigated by the Administrator. The facility management staff has attended a Webinar on Resident to Resident Elder Mistreatment (RREM) and what is reportable. Concern Forms regarding Nursing Care or alleged abuse, neglect, and/or mistreatment will be forwarded immediately to the Supervisor or the Administrator/Director of Nursing for investigation and reporting when necessary. Incident and Accident Reports will be reviewed during the morning Clinical Meeting. Reports that have the potential to be Abuse/Neglect/Mistreatment will be investigated and reported per State and Federal Regulations by the IDT. The Administrator and/or designee will review the Concern Forms and Incident and Accident Reports weekly for any noncompliance. Noncompliant Concern Forms and/or Incident and Accident Reports will be investigated and reported to OHLS per State and Federal Regulations. **Monitoring:** The QAPI Committee will evaluate effectiveness of the systemic changes based on additional interventions as [illegible] to ensure compliance.	

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F 225	Continued From page 16 abuse, neglect or mistreatment were reported and/or investigated. These incidents involved 12 residents (#2, #11, #27, #30, #31, #42, #44, #68, #76, #99, #114, #121). The findings were: 1. Review of grievances revealed issues were identified that required reporting and investigation to rule out abuse/neglect/mistreatment. The following concerns were identified: a. A concern form initiated 12/11/15 related to resident #114. The resident alleged s/he did not receive pain medications, call light times were excessive and when an aide came in "[the] aide told [him/her] that they were short-staffed and she couldn't help [him/her]. Resident also reports that the aide said 'you should stop your whining because therapy is going to be worse'." The concern form also showed the resident stated his/her pain management needs and other needs were "not being met" and "this is abuse." b. A concern form initiated on 12/11/15 related to resident #31 showed the resident alleged an aide being "extremely rude...yelling at me...throwing clothes at me." c. A concern form initiated on 12/11/15 related to resident #121 showed the resident "waited for 8 hours to go to the restroom." The form showed a CNA contributed this to not having the right kind of toilet. The action taken showed the Occupational Therapist manager got a bed side commode for the resident. d. A concern form initiated on 12/28/15 related to resident #27. This resident alleged medications were not being provided, a named RN was "very rude", and another named RN "wanted to make wound bleed when cleaning it-it hurt." e. A concern form initiated on 12/19/15 related to resident #2 who alleged another named	F 225	reassess the need for continued monitoring based on compliance until resolved	

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F 225	Continued From page 17	F 225		

resident was "very mean to other residents...calling other residents names, including [him/her)."

f. A concern form initiated on 12/11/15 related to resident #2 showed the resident was "very upset near tears" the resident reports s/he "feels that another resident is being neglected [and] abused."

g. Review of the concerns form initiated on 12/27/15 related to resident #76 showed the resident was "scared" and "doesn't feel safe" around resident #44.

h. Review of the 12/27/15 concern form related to resident #99 showed this resident was "scared and yelling and crying." The fear was due to resident #44 being in resident #99's room standing over him/her. The concern form further showed "It is very apparent [s/he] is afraid of [him/her]. I am concerned about the safety of the other residents."

i. The 12/28/15 concern form related to resident #42 showed resident #44 was pulling resident #42 out of his/her room with the oxygen cord. When trying to redirect resident #44, s/he became agitated. The concern form further showed "very concerned about the safety of others."

j. The 12/26/15 concern form related to resident #11 showed resident #44 was in resident #11's room and resident #44 "pushed the resident out of the room. Resident #11 was "so upset [s/he] was shaking." The upset resident talked about the other resident being a "bad [man/woman]."

k. Review of the facility "Abuse log" for December 2015 and January 2016 showed 3 reported allegations which did not include the above mentioned examples. Review of the State survey agency logs failed to show these

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F 225	Continued From page 18 allegations were reported to the licensing division. Review of the "action" for the 4 concerns related to resident #44 showed it did not address each individual concern form. There was one description of actions taken to show the facility was working with the family and a care plan meeting was scheduled 1/11/16 and it was signed by the administrator on 1/11/16 with a note that more resolution was needed. I. Interview with the corporate RN and the DON on 1/15/16 at 4:30 PM verified the resolution to some grievances needed to be better. Further, they verified concerns with allegations of abuse and neglect had not been assigned well, had not been reported, and may not have been adequately investigated. 2. Review of the 12/20/15 "SBAR Communication Form and Progress Note" for resident #58 showed "Resident c/o [complaints of] left groin pain. Had c/o left leg pain to off going shift, stating she thought [his/her] leg was broke. No report of incident with resident during previous shift. Resident states that [s/he] fell, hitting [his/her] head on [his/her] nightstand this morning, although resident is not a reliable historian. Resident noted with raised reddened area to left buttock & reddened area to left side of head. ROM [range of motion] to Left leg guarded d/t [due to] c/o left groin pain. Denies headache." The following concerns were identified: a. Continued review of the 12/20/15 "SBAR Communication Form and Progress Note" showed the author "Spoke with RCS [Resident Care Specialist]...who had assisted resident last night. Resident was having difficulty standing to transfer in to shower chair after having a loose BM [bowel movement] early this morning and was lowered to the floor."	F 225		

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F 225	Continued From page 19 b. Further review of the medical record showed no evidence the early morning fall was reported by the RCS at the time of occurrence, no evidence the resident was assessed at the time of the fall for injury, and no evidence the fall was investigated or that abuse was ruled out. c. Review of a progress note dated 12/22/15 and timed 2 PM showed the resident complained of increased pain, and the physician ordered an x-ray. d. Review of a progress note dated 12/22/15 and timed 7:45 PM revealed the resident had a left hip fracture. e. Interview with the DON on 1/15/16 beginning at 2:05 PM revealed she did not know how the resident's hip was broken, and was unaware of the note indicating the resident had fallen on 12/20/15. She confirmed there had been no investigation of the 12/20/15 fall, and no investigation into the resident's broken hip to rule out abuse. 3. Review of the 10/18/15 admission MDS assessment showed resident #44 was admitted to the facility with diagnoses that included restlessness and agitation. The assessment indicated the resident had physical behaviors directed at others that put others at significant risk for physical injury, and significantly intruded on the privacy of others. The following concerns were identified: a. Review of the 11/7/15 psychosocial assessment revealed the resident had been referred to a geriatric behavioral health unit due to behaviors that included shaking his/her penis in a female resident's face. b. Review of the State survey and certification agency logs on 1/15/16 showed no report of an allegation of sexual abuse was made to that	F 225		

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F 225	Continued From page 20 agency. c. Interview with the DON on 1/15/16 at 6:57 PM confirmed no report had been made of an allegation of sexual abuse, and there was no documentation of an investigation. 4. Interview with resident #30 on 1/13/16 at 12:42 PM revealed s/he had provided the facility with a written allegation of neglect on 1/9/16. Review of the 12/15/15 admission MDS assessment revealed the resident was cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15. The following concerns were identified: a. Review of the State survey and certification agency logs on 1/15/16 showed no report of an allegation of neglect was made to that agency. b. Interview with the DON, ADON and corporate RN on 1/15/16 beginning at 2:05 PM confirmed no report of an allegation of neglect was made.	F 225	~~F241 Dignity and Respect of~~ Individuality It is the practice of the facility to promote care for residents in a manner and in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Corrective Action Resident #78 will be assessed for level of assistance needed with meals, including use of clothing protector and adaptive equipment by Director of Nursing or designee. Care plan and CNA assignment sheet will be updated as necessary to reflect changes. Resident #78 is receiving timely assistance with meals.	2/23/16
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and medical record review, the facility failed to promote care in a manner to maintain dignity for 2 of 35 sample residents (#78, #108). The findings were: 1. Review of the 12/7/15 admission MDS	F 241	Resident #108 will have a 3 day voiding pattern completed to re-establish voiding pattern. After completion of voiding pattern a new bladder evaluation will be completed and care plan updated with new interventions for incontinence management by the Director of Nursing or designee. Care plan and CNA assignment sheet will be updated as necessary to reflect changes.	

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F 241	Continued From page 21 assessment showed resident #78 required limited assistance with 1 person physical assistance for eating. Observation on 1/14/16 beginning at 5:51 PM showed resident #78 was sitting at a table in the dining room as the dinner meal was served in separate bowls. The resident picked up a spoon and began to feed him/herself, but appeared to have difficulty keeping the food on the spoon and bringing the spoon to the mouth due to hand tremors. At 6:05 PM CNA #1 approached the resident, asked if s/he needed assistance with eating, and then assisted the resident to another table next to another resident who required assistance. Interview with the resident at 6:15 PM revealed "they said they were going to help, but I haven't seen anybody. I was going to leave but they said they'd be back to help. Got food all over myself." Observation showed the resident wearing a clothing protector with crumbs and pieces of food on it. At 6:20 PM (29 minutes after the meal was served and 15 minutes after first being offered assistance), CNA #2 arrived and attempted to assist the resident with the meal. The resident declined further assistance, stating s/he was no longer hungry. There was approximately 50% of food observed remaining in the resident's bowls. 2. Review of the 12/28/15 care plan revealed resident #108 required staff assistance with toileting and incontinence care due to dementia and inability to transfer without staff assistance. According to the care plan, revised 12/18/15, staff were directed to offer assistance and "toilet" upon rising, before and after meals, at bedtime, and as needed. Observation on 1/12/16 at 6:50 AM revealed CNAs #3 and #4 provided urine and fecal incontinent care for the resident before they wheeled him/her to breakfast. Continued	F 241	Identification of Others A visual observation audit of residents at meal time will be completed by Rehab Manager or designee to identify any residents with dignity concerns r/t dining. For those identified further review will be completed by interdisciplinary team and care plans and CNA assignment sheets updated to reflect changes. The Director of Nursing or designee will identify residents who are incontinent of bladder. The incontinence care plans for those identified will be reviewed and updated as needed. CNA assignment sheets will be reviewed for incontinence interventions and updated as needed. Systemic Changes The Director of Nursing or designee will educate staff on dignity, including timely assistance with meals and timely assistance with toileting and incontinence management. The Director of Nursing or designee will complete random visual dignity observation audit of 10 residents 3 times weekly for one month and then monthly for two months. The audit will include checking that resident, resident clothing and wheelchair are clean after meals and	

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F 241	Continued From page 22 observation revealed the resident sat in the hallway and activity room after eating breakfast. At 10:30 AM, after painting the resident's fingernails, the activity staff positioned the resident in front of the television. At that time the resident had a fecal odor. The resident remained in the activity room until 11:50 AM when the bath aides #1 and #2 wheeled the resident to the shower room and removed the urine and feces-soiled disposable brief. Interview on 1/15/16 at 11 AM with CNA #4 revealed sometimes staff did not toilet the resident before and after meals because the resident refused. However, the continued observation from 6:50 AM to 11:50 AM revealed staff did not offer the resident toileting assistance.	F 241	timely assistance is provided at meals. Corrective actions will be taken as needed for any identified concerns. The Director of Nursing or designee will complete visual observation audits of incontinence 3 times weekly on a random sample of 10 residents for one month and then monthly for two months. The audit will include monitoring for timely assistance to bathroom and incontinence and provision incontinence interventions per care plan. Corrective action will be taken as appropriate for any concerns identified.	
F 250 SS=G	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interview, the facility failed to ensure medically-related social services issues were addressed for 2 of 7 sample residents (#31, #76) with these types of needs. The failure resulted in a negative psychosocial outcome to resident #76. The findings were: 1. Review of the 11/9/15 admission MDS assessment for resident #76 revealed diagnoses	F 250	Monitoring The Director of Nursing will report the findings to the QAPI Committee to evaluate the effectiveness of the systemic changes and implement additional interventions as needed to ensure compliance and then reassess the need for continued monitoring based on compliance until resolved. F 250 Provision of Medically Related Social Service It is the practice of the facility to provide medically-related social services to attain or maintain the highest practicable	2/23/16

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F 250	Continued From page 23 that included anxiety disorder. Continued review of the assessment showed the resident triggered for further assessment of communication and psychosocial well-being. Review of the communication CAA revealed the resident was "...resistant to Long Term Care and a move to this facility, [s/he] has a Dx [diagnosis] of anxiousness..." Review of the psychosocial well-being CAA revealed the resident reported "...mood issues which could be attributed to [his/her] new admission in the facility and may take time for adjustment to [his/her] new environment." The following concerns were identified: a. Review of the progress note dated 11/9/15 and timed 7:39 PM revealed the resident told a staff member s/he would not take "...the pills because [s/he] wants to die..." b. Review of the progress note dated 11/16/15 and timed 1:58 PM showed the resident had been moved out of the facility by family. Review of MDS data showed the resident was readmitted to the facility on 11/20/15. c. Interview with the administrator on 1/15/16 at 12 PM revealed the resident was removed from the facility by family members who did not have the authority to do so, and the resident's relative who did hold power of attorney ensured the resident's return to the facility and restricted the other family member's ability to contact the resident. d. Review of the progress note dated 11/21/15 and timed 2:43 PM revealed the resident looked "...down and depressed, not smiling and frequently with a frown on [his/her] face..." e. Review of a social service note dated 11/25/15 and timed 3:47 PM showed "[Resident name] is alert and oriented to person, place, although [s/he] can be confused with time or date.	F 250	physical, mental, and psychosocial well-being of each resident, **Corrective Action** A Social Services assessment was completed for resident #31 and her care plan has been updated to reflect resident's current status. Resident #31 blinds are in working order Resident #76: A Social Service's Assessment was completed for resident #76 and her care plan was updated to reflect the resident's current status. **Identification of Others** An audit will be completed by Social Service Director or designee to identify any residents with mood issues or symptoms of depression. For the identified residents the Social Service Director will evaluate current mood, depression symptoms and behavior, update social service note to reflect resident status, review medications and care panned interventions and any outside services provided. The care plan will be updated as needed to reflect resident needs and interventions for mood issues and symptoms of depression, Physician will be notified and referrals will made to other agencies as needed.	

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F 250	Continued From page 24 Daily decision making is currently moderately impaired. Depression features are noted with [resident name] as being down at times overall. A history of behavioral symptoms include being paranoid at times and trying to elope from the facility..." f. Observation of the resident on 1/11/16 at 2 PM showed his/her room was located on the secure (locked) dementia unit. The resident was seated in a chair in his/her room. The resident was awake, but was not engaged in any activity. The room was dark; no lights were on and the window blinds were closed. Interview with the resident at that time revealed the blinds didn't work, and couldn't be adjusted, "So they stay that way all of the time." The resident then began to weep, and stated, "I'm terribly, terribly unhappy!" g. Further review of the medical record failed to show any social service notes after 11/25/15. h. Interview with the social services director on 1/15/16 at 4:45 PM revealed the resident did have an understanding of the situation with his/her family members and was distressed by it. He noted the resident was angry at times, and suffered anxiety. He further stated a care plan to address the resident's distress had been developed just that day. 2. Review of the medical record for resident #31 revealed s/he was admitted on 10/15/15 after a stroke. This review showed the stroke affected the resident's balance, vision, and cognitive ability. According to the care plan, revised 12/27/15, staff were directed to administer antidepressant medications and observe/document/report adverse reactions and effectiveness. Observations on 1/11/16 revealed the resident was awake in bed from 4:30 PM to 5:45 PM. At 5:45 PM s/he ate in the dining room	F 250	Systemic Changes The Social Service Consultant or designee will provide education to Social Service staff on identification, evaluation and management of mood issues and depression and documentation before date of compliance. The education will include interventions and care planning. The facility has made arrangements for mental health services to be provided on site to facilitate prompt and consistent response to resident mental health needs beginning February 2016. The Director of Nursing or designee will review incident / accident reports, 24 hour report and the clinical dashboard in Point Click Care in morning meeting daily Monday or Friday to identify any resident change of condition. The Social Worker or designee will attend morning clinical meeting to identify any residents with mood issues, symptoms of depression or change in behaviors. The Social Worker will follow up promptly on any identified concerns and document actions taken. The Social Service consultation will be provided monthly for the next 3 months to monitor effective provision of social service and documentation. Any recommendations by consultant will be reviewed and follow taken as needed. The Administrator or designee will complete random audit weekly of documentation and interventions provided to residents identified to have mood issues, symptoms or depression	

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F 250	Continued From page 25 and returned to his/her bed at 6:15 PM. On 1/12/16 the resident was observed in bed from 9:20 AM to 11:30 AM. The following concerns were identified: a. During an interview on 1/12/16 at 9:45 AM the resident sobbed and stated s/he was depressed because something was making him/her sleep "all the time", his/her vision was limited due to the stroke and cataracts on both eyes, family was far away and could not visit often, and there was nothing to do all day at the facility. b. During a second interview on 1/14/16 at 5 PM, the resident revealed s/he continued to feel "sad", and it was "hard to keep from feeling depressed." c. Interview with the social services director on 1/14/16 at 6:30 PM revealed a social services admission assessment had not been completed for the resident. At that time the social services director stated he was not aware of the resident's depressed feelings. d. Interview on 1/15/15 at 7:30 AM with CNA #5 revealed the resident liked to stay in his/her room and usually got up for breakfast then returned to bed. e. Interview with the social services director on 1/15/16 at 8:15 AM revealed he talked with the resident after talking with the surveyor, and determined additional and revised interventions were needed to address the resident's depression.	F 250	or behavior changes. Corrective actions will be taken based on findings. **Monitoring** The Administrator or designee will report the findings to the QAPI Committee to evaluate the effectiveness of the systemic changes and implement additional interventions as needed to ensure compliance and then reassess the need for continued monitoring based on compliance until resolved. **F-253: Housekeeping & Maintenance Services.** **Corrective Actions:** Resident Room #202has had the edge of the floor along the baseboard and the warped baseboard repaired. Resident room 211 has had the area around the toilet cleaned and caulked. Resident room 503 has had the blinds repaired. Resident room 610 has had the window repaired. Resident room 203 has had the wall repaired.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

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F 253	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure a safe and sanitary environment in 4 of 6 resident areas (200, 400, 500, 600 hallways). The findings were: Observation on 1/15/16 beginning at 10:45 AM revealed the following concerns with floors and baseboards, windows and blinds, walls, sinks, and shower rooms: Regarding floors and baseboards: 1. In resident room 202, the edge of the floor along the baseboard to the left of the bathroom had an accumulation of dirt and debris approximately 2 feet long. Additionally, the baseboard was warped and chipped at the corner. 2. In resident room 211, the floor along the perimeter of the toilet was discolored and soiled with dark debris. Further, the caulking around the base of the toilet was missing. 3. Interview during the observation with the maintenance director confirmed the identified areas needed cleaning and/or repair. Regarding windows and blinds: 1. In resident room 503, the window blinds were in a closed position, with the slats pointed down. The string that operates the slat positioning was located at the top of the blinds and required effort to reach and operate.	F 253	Resident room 504 has had the drain cover repaired. Resident room 611 has had the drain access cover replaced and the wall repaired. Resident room 612 has had the faucet replaced and the leak fixed. Resident room 504 had had the faucet replaced.. Resident shower room in the 400 hallway has had the drain cover replaced. Resident shower room in the 600 hallway has had the tiles replaced and the baseboard fixed. **Identification of others:** The Maintenance Director has completed a room to room check for faulty blinds, sinks needing repair, floors needing repair, and windows that may be cracked and remedied them. **Systemic Changes:** The Maintenance Director and/or designee will conduct weekly room checks for areas of disrepair and fix the issues in a timely manner.	

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F 253	Continued From page 27 2. In resident room 610, the lower left window was cracked. 3. Interview during the observation with the maintenance director confirmed the window blinds needed to be re-strung and the cracked window needed to be replaced. Regarding walls: 1. In resident room 203, the wall above the bed near the window had numerous areas of chipped paint and gouges. 2. In resident room 504, the drain access cover to the left of the sink was loose which exposed a metal edge and bare drywall behind it. 3. In resident room 611, the drain access cover to the left of the sink was missing, which left a hole in the wall approximately 6 inches square and exposed piping inside the wall. 4. Interview during the observation with the maintenance director verified the identified areas needed to be repaired. Regarding sinks: 1. In resident room 612, the hot water handle had chipped chrome and exposed rust approximately 1/2 inch in diameter. Additionally, water leaked from the base of the handle when the water was turned on. 2. In resident room 504, the hot water handle was not secured to the sink base. 3. Interview during the observation with the maintenance director confirmed the sink handles	F 253	Monitoring: The QAPI Committee will evaluate effectiveness of the systemic changes based on additional interventions as needed to ensure compliance then reassess the need for continued monitoring based on compliance until resolved	

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F 253	Continued From page 28 needed to be repaired or replaced. Regarding shower rooms: 1. In the shower room in the 400 hallway, a 6-inch diameter drain cover on the floor near the door was partly pushed down into the drain hole 1/2 inch deep, which exposed the tile edge around the drain. 2. In the shower room in the 600 hallway, there were three tiles measuring 6 inches along the base of the wall to the right of the door that were cracked and chipped. Additionally, the baseboard along the bathtub and the wall under the shower was coming loose from the wall, with an accumulation of dirt and debris behind the baseboard. 3. Interview with the maintenance director during the observation confirmed the identified areas needed to be repaired.	F 253	F-254: Clean Bed/Bath linens in Good Condition. **Corrective Action:** Towels to appropriately be distributed in resident rooms and shower rooms have been ordered. **Identification of Others:** The Housekeeping and Laundry Manager or designee has done a room to room audit for an adequate amount of towels. Rooms that did not have adequate amount of towels were stocked with the appropriate amount of towels. **Systemic Changes:** Housekeeping Laundry Manager will do an inventory audit for towels weekly for one month then monthly thereafter to ensure adequate numbers of towels to supply resident's rooms. An order will be placed as needed to keep the towel inventory adequate. **Monitoring:** The QAPI Committee will evaluate effectiveness of the systemic changes based on additional interventions as needed to ensure compliance then reassess the need for continued monitoring based on compliance until resolved	2/23/16
F 254 SS=E	483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, the facility failed to provide an adequate supply of bath linens for resident use. The census was 111. The findings were: 1. Observation on 1/12/16 at 9:30 AM revealed a shelving unit for storing various linens, including sheets and towels. Further observation showed	F 254		

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F 254	Continued From page 29 the shelving marked "bath towels" was empty and the shelving marked "hand towels" had a small supply available. 2. Interview on 1/12/16 at 11:20 with laundry aide #1 revealed "she can't keep linens on the shelves," and she did not feel there were enough linens for the whole facility, "especially bath towels and hand towels." 3. Interview on 1/13/16 at 12:42 PM with resident #30 revealed during the previous shower s/he received, s/he had to dry off with a hand towel as no bath towels were available. 4. Observation on 1/12/16 at 11:50 AM revealed bath aide #1 and #2 provided extensive assistance with shower and toileting for resident #108. After showering, the aides used hand towels to dry the resident. Interview with bath? aide #1 and bath aide #2 on 1/15/16 at 8:48 AM revealed they sometimes needed to use hand towels instead of bath towels because they "run out" of bath towels.	F 254	F 281 Services Meet Professional Standards It is the practice of the facility to strive to ensure that services provided or arranged by the facility meet professional standards of quality. Corrective Action Resident #20's physician has reviewed blood sugars and insulin orders. Wound treatment orders for #52 were reviewed and updated. Resident #25's physician reviewed resident's antihypertensive orders and blood pressure results and blood pressure parameters were discontinued on 2.3.16 Resident #88's physician has reviewed blood sugar results and insulin orders. Identification of Others An audit has been completed by Director of Nursing / designee, to identify any residents that are diabetic and have finger stick blood sugar orders and / or insulin orders. The audit includes checking for parameters for physician notification of blood sugar results and notification of physician of results	2/23/16
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure physician's orders were followed for 4 of 37 sample residents (#20, #25, #62, #88). The findings were:	F 281		

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FORM APPROVED
OMB NO. 0938-0391

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F 281	Continued From page 30 1. Review of the medical record showed resident #20 required daily medication for Diabetes Mellitus. Review of the January 2016 medication review form showed the physician ordered blood sugar levels before meals and at bedtime and sliding scale insulin based on the results of the blood sugar levels, Lantus insulin 40 units at bedtime, and Metformin 500 mg pills twice daily. Further review of the medication review form showed the parameters for the sliding scale insulin administration addressed blood sugar levels up to 350 (this number is milligrams of glucose per deciliter of blood), but failed to address blood sugar levels above 350. The following concerns were identified: a. Review of the January 2016 MAR showed the resident did not receive the sliding scale insulin dose and/or staff did not check the resident's glucose level at various times from 1/4/16 to 1/9/16 because s/he refused. b. Review of the nursing progress notes and documented communication with the physician showed staff did not report their inability to obtain the blood sugar levels as ordered, elevated blood sugar levels above 350, and omitted insulin doses to the physician. c. Interview with the ADON on 1/14/16 at 8:45 AM revealed staff should have reported the elevated blood sugar levels and lack of insulin administration to the physician. He further stated the physician's order for sliding scale insulin was unclear regarding levels above 350, and the nurses should have clarified the order. 2. Review of the December 2015 and January 2016 MARs showed resident #25 had orders related to his/her diagnosis of hypertension. These orders were dated 11/10/15 and included "Lisinopril Tablet 2.5 mg, 1 tablet daily in the	F 281	outside of the parameters and correct administration of insulin per orders. Corrective actions will be taken as needed. An audit will be completed by Director of Nursing or designee of medication and treatment administration records for the past 2 weeks to identify any instances where medication or treatment was not provided due to pattern of resident refusal or supplies not being available. The audit will also include checking that vital signs completed as needed and any additional parameters for medication administration are followed. Corrective actions will be taken as needed including physician notification. Systemic Changes The Director of Nursing or designee will educate the licensed nursing staff, on or before date of compliance, regarding the notification of the physician and resident's legal representative any acute changes in condition and noting this notification in the medical record. The education will include physician notification of patterns of refusals of medication or treatment, physician notification when supplies or medications are not available and	

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F 281	Continued From page 31 morning. Hold if systolic blood pressure (BP) less than 100" and "Metoprolol tartrate tablet 25 mg, give 0.5 tablet by mouth 2 times per day. Hold if systolic BP less than 110 or heart rate less than 60." Further review of the MARs showed the resident received these medications daily except on 1/3/16 when both medications were shown to be held due to the resident being hospitalized. Also on 1/2/16, 1/8/16, and 1/9/16 the 9 PM dose of Metoprolol was held "due to condition." The following concerns were identified: a. Review of the MARs and the medical record failed to show the BP or heart rate were taken prior to the medications being administered. In addition, the progress notes failed to show the resident was out of the facility on 1/3/16, or why the medication was held on the other dates. b. Review of the vital sign documentation in the chart showed in December 2015 the resident's heart rate was taken only 18 times with no values less than 60. On 1/13/16 the January vital signs for heart rate were reviewed, and there were only two times when these values were recorded with none below 60. c. Review of the December 2015 BP documentation showed only 18 times when the values were recorded. On 12/10/15 at 6:51 PM the value was 89/60, and the metoprolol was administered at 9 PM according to the MAR. d. Review of the January 2016 documentation for BP showed only 5 times when the value was recorded. e. Interview with the DON on 1/15/16 at 5:30 PM verified she was unable to find any additional documentation of vital signs and confirmed they should be taken prior to administration of these medications.	F 281	obtaining alternative orders until supplies or medications are available and following parameters on physician orders and obtaining vital signs as needed.. The education will also include obtaining parameters for physician notification of finger stick blood sugar results, notification of physician when blood sugar results are outside of the parameters, and following physician orders for insulin. The Director of Nursing or designee will audit finger stick blood sugar orders and results and insulin administration weekly for 1 month for correct administration and physician notification of results outside of parameters. After 1 month, random audit of 3-5 finger stick blood sugar results and follow up will be completed weekly for 2 months. Corrective actions will be taken as needed based on findings. The Director of Nursing or designee will complete an audit of medication and treatment records weekly for 1 month and then a random audit of 25% of records weekly for 2 months for patterns of refusals, unavailability of supplies or medications and physician notification and obtaining vital signs as ordered and administering medication per physician	

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F 281	Continued From page 32 3. Review of the 11/12/15 quarterly MDS assessment showed resident #88 had diagnoses that included diabetes. Review of the physician orders showed the resident was to receive 5 units of NovoLog insulin before meals, with the medication to be held if the resident's blood sugar was below 150. Review of the January 2016 MAR revealed the following concerns: a. There was no evidence the resident's blood sugar was checked or the insulin administered prior to 10 meals between 1/1/16 and 1/14/16. b. The resident was administered insulin on 3 occasions when the blood sugar was indicated to be below the specified parameter of 150. c. The resident was administered insulin 11 times with no documented blood sugar. d. Interview with the DON, ADON, and corporate RN on 1/15/16 at 2:15 PM confirmed the MAR indicated the resident received insulin when the blood sugar was below the specific parameter. Interview with the DON on 1/15/16 at 8 PM revealed there was no additional documentation to provide related to the resident's insulin administration. 4. Review of the 11/12/15 admission MDS assessment showed resident #52 was admitted with a surgical wound, and was receiving surgical wound care. Further, the resident required the extensive assistance of 2 or more persons for most ADLs. Review of the resident's care plan for skin issues showed an intervention dated 11/16/15, "Observe wound healing and maintain wound vac [vacuum] as dressing..." Review of physician orders showed a 12/24/15 order for "Wound vac to R [right] buttock wound. Wound vac maintenance daily with dressing change on MON [Monday], WED [Wednesday] and FRI	F 281	orders. Corrective actions will be taken as needed based on findings. **Monitoring** The Director of Nursing will report the findings to the QAPI Committee to evaluate the effectiveness of the systemic changes and implement additional interventions as needed to need for continued monitoring based on compliance until resolved.	

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F 281	Continued From page 33 [Friday] every day and night shift..." The following concerns were identified: a. Review of the 12/27/15 late entry for 12/26/15 progress note showed "...was going to change wound vac to right buttock area, no wound canisters were found..." b. Review of the 12/27/15, timed 6:27 PM, progress noted showed "wound continues to be without wound vac..." c. Further review of the medical record showed the order for the wound vac was not discontinued until 12/30/15. d. Interview with the DON, ADON and corporate RN on 1/15/16 beginning at 2:05 PM confirmed the resident's wound vac was not changed according to the physician's orders because the facility did not have the needed supplies. Further, the DON confirmed the physician was not contacted regarding the facility's inability to apply the wound vac until 12/30/15.	F 281	F-309: Provide Care/Services for Highest Well Being It is the practice of the facility to strive to ensure that each resident receives the necessary care and services to attain or maintain the highest practicable physical or mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. **Corrective Action** Resident #116 no longer resides at the facility. Resident #20's physician has reviewed resident's blood sugars and insulin orders. Wound treatment orders have been reviewed and updated for resident #52. The physician reviewed resident #25's antihypertensive orders and blood pressure results and blood pressure parameters were discontinued. The physician has reviewed #88's blood sugar results and insulin orders. **Identification of Others** An audit will be completed by Director of Nursing / designee, to identify any	4/23/16 PO
F 309 SS=G	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 adequate care and/or timely response to a change of	F 309		

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F 309	Continued From page 34 condition for 5 of 35 sample residents (#20, #25, #52, #88, #116). This failure resulted in actual harm for 2 residents (#20, #116) who were transported to the hospital for acute care. The findings were: 1. Review of the 5/12/15 interdisciplinary team note showed resident #116 was admitted to the facility for rehabilitation after lumbar surgery, and infection of the surgical wound. The following concerns were identified: a. Review of the nursing note dated 5/27/15 and untimed showed "Resident crying out this am, very drowsy from pain meds [medications] earlier & flexeril [a muscle relaxant], c/o [complains of] that [s/he] couldn't feel [his/her] legs, difficulty sitting up @ [at] bedside, very adamant that [s/he] wanted to lay in bed..." b. Review of the 5/28/15, untimed, late entry for 5/27/15 nursing note showed "Request to get resident in to see [physician name] @ [clinic name] d/t [due to] increased pain and difficulty moving [his/her] legs. [S/he] was rescheduled with an appt. [appointment] for 29th. Incision noted to be without s/sx [signs/symptoms] infection and resident was ext X 1 asst [extensive assist of 1 person] with transfer to recliner with nurse." c. Further review of the medical record showed no evidence the physician was contacted directly about the resident's increased pain and inability to feel his/her legs. d. Review of the 5/29/15 nurse's note timed at 11:50 PM indicated the resident had an appointment at the clinic, and returned with new orders. Notes from this appointment were requested from the facility, and were not available. e. Review of the 5/31/15 "SBAR	F 309	residents with an acute change of condition within the last 30 days to ensure that the resident's physician and legal representative was notified of the change, orders obtained and written as needed and care plan updated when needed. Corrective actions will be taken as needed. An audit has been completed by Director of Nursing / designee, to identify any residents that are diabetic and have finger stick blood sugar orders and / or insulin orders. The audit includes checking for parameters for physician notification of blood sugar results and notification of physician of results outside of the parameters and correct administration of insulin per orders. Corrective actions will be taken as needed. An audit will be completed by Director of Nursing or designee of medication and treatment administration records for the past 2 weeks to identify any instances where medication or treatment was not provided due to pattern of resident refusal or supplies not being available. The audit will also include checking that vital signs completed as needed and any additional parameters for medication administration are followed.	