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

5/10/16

PRINTED: 04/28/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 BASIN, WY 82410

(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 The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living CAA- Care Area Assessment CNA- Certified NurseAide 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		
F 168 SS=B	483. 10(g)(2) RIGHT TO INFO FROM/CONTACT ADVOCATE AGENCI ES A resident has the right to receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the correct contact information for the State Survey Agency was posted on 1 of 1 information boards. The findings were: Observation of the information board located in the main area of the facility showed the mailing address, the phone number and the name of the State Survey Agency was out of date. Interview with the DON on 4/13/16 at 4:05 PM verified the information needed to be corrected so it was	F 168	The facility will ensure each resident has access to information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. This will be accomplished by: A.) All residents could be affected. B.) New letters were ordered, information board updated with correct information. 4/29/16 C.) All residents will be made aware of updates to the information board and availability. Residents were informed at resident council on 5/5/16 with a repeat reminder on 6/2/16. D.) Develop a monitoring tool to ensure accuracy of information to be reported on quarterly at QA meeting by the Social Services. Appropriate follow up action will be initiated by the QI committee as necessary.	5/29/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mona Mobert — TITLE: Administrator — (X6) DATE: 5/10/16

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
MAY 10 2016
WY Dept of Health
Healthcare Licensing and Surveys

Accepted w/change to pg 4

Spoke w/ NHA & DON Regarding change and DOC for all tags is 5/29/16

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F 168	Continued From page 1 accurate for the residents.	F 168		
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 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.	F 225	This facility will ensure that all CNA's hired will be screened appropriately to ensure there are no findings on the CNA abuse registry and all investigations will be done thoroughly and any follow ups will be completed. The policy on abuse will be more specific to the screening procedure. This requirement will be met as evidenced by: A.) All residents could be affected. B.) Prior to hiring of any new nursing assistant there will be evidence that the CNA abuse registries will be checked, reviewed and on file. The Following registries will be checked: a.) DFS Abuse Registry b.) National Criminal Search c.) Department of Health Licensing Registry. This facility will ensure that all investigations will be thoroughly done by interviewing random residents and	

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F 225	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, review of investigations, employee file review and policy and procedure review, the facility failed to ensure 1 of 2 abuse investigations reviewed was thorough. In addition, the facility failed to ensure 2 of 2 CNAs (CNA #1, CNA #2) hired were screened to ensure no findings on the nurse aide abuse registry. The findings were: 1. The following concerns were identified related to screening CNAs: a. Review of the employee file showed CNA #1 was was a recent hire to the facility with a hire date of 4/5/16. The review failed to show any evidence the CNA abuse registry was checked prior to hire to rule out abuse findings. b. Review of the employee file showed CNA #2 was hired in 2013 and was under review related to resident concerns. The review failed to show any evidence the CNA abuse registry was checked prior to hire to rule out abuse findings. c. Interview with the human resource manager on 4/13/16 at 4:40 PM revealed she did not check this registry, and did not know of the requirement. Interview with the DON on 4/14/16 at 9:35 AM verified she was unaware of the requirement to check the CNA abuse registry. d. Review of the 4/15/15 revised policy and procedure on the subject of "Abuse" showed the section on prevention included screening but, was not specific on the procedures. The policy showed "Screening will include all appropriate background checks as required."	F 225	Staff that were not directly involved in the allegation at hand. All documentation required in the investigation will be tracked and charted on as part of the corrective action. C.) The Social Service Director will develop a monitoring tool, confirming that the abuse registry for current as well as new hire CNA's has been checked and a copy of the results will be placed in their employee file. Human resources to report to QA quarterly. Social Services will ensure proper documentation is met. D.) Social Services will add to the Abuse log, a column for # of residents interviewed as well as another column for follow-up charting, which will be monitored quarterly at the QI meeting.	5/29/16

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F 225	Continued From page 3 2. Review of the 1l/16 investigation related to an allegation of abuse/neglect showed it was not thorough. The allegation involved CNA #2 and 3 residents. These 3 residents made allegations in a resident council meeting that included neglect of care, and verbal and physical abuse. The investigation included interviews with the residents who made the allegations and other staff members. The findings of the investigation showed the CNA was provided disciplinary action and education, and was allowed to continue working. There was also a plan for the DON and social service director to "meet with the affected residents and a random selection of residents once per month for 3 months to follow-up on this situation." The following concerns were identified: a. The investigation failed to include interviews with other residents not involved with the original allegations. b. Interview with the social service director on 4/14/16 at 8:25 AM verified she had not thought about interviewing other residents during the 1n/16 investigation. She also verified the follow-up plan had not been done. c. Interview with a group of 13 residents on 4/12/16 at 1:30 PM revealed current and historical concerns with CNA #2. Ongoing allegations which included neglect of care and verbal abuse were made by 4 residents during this meeting and 1 resident brought forth current concerns about the CNA during a confidential interview on 4/13/16 at 1:30 PM. Based on these comments the survey team informed the facility administration about the allegations of abuse/neglect at that time for their reporting and investigation.	F 225	F226 This facility will ensure that the abuse Policy and procedure states the Requirements for screening new hires for The CNA position. The requirement will be met as evidenced By: A.) All residents may be affected. B.) Abuse policy was revised to include The need to check the CNA abuse registries. Human resources will keep documented Proof that this has been done. C.) The policy will include: a.) DFS Abuse Registry b.) National Criminal Search c.) Department of Health Licensing d.) Residents not immediately involved in the issue will be interviewed. e.) Staff to be interviewed as appropriate. f.) Families to be interviewed as appropriate. g.) The Director of Social Services and/or the DON will coordinate efforts of appropriate disciplines for investigation to ensure satisfactory resolution of the incident.	
F 226	483.13(c) DEVELOP/IMPLMENT	F 226		

5/10/16 change approved by Marjorie NHA

5/29/16

QR 5/10/16

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F 226 SS=D	Continued From page 4 ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on policy and procedure review and staff interview, the facility failed to develop the abuse prohibition policy and procedure to ensure required screening procedures in regard to CNAs, and thorough investigation techniques. The findings were: Review of the 4/15/15 revised policy and procedure on the subject of "Abuse" showed the section on prevention included screening; however, the information was not specific as to the procedures. The policy showed "Screening will include all appropriate background checks as required." Additionally, the area of the policy and procedure related to investigation was not developed to include what elements/techniques would allow for a thorough investigation. The policy showed "Director of Nursing and Administrator will coordinate efforts of appropriate disciplines for investigation and satisfactory resolution of incident. They will provide adequate documentation of investigation of alleged abuse and take necessary steps to ensure prevention of further abuse..." Interview with the social service designee on 4/14/16 at 8:25 AM verified the policy and procedure did not include developed procedures in these areas.	F 226	D. A monitoring tool will be developed and reported on quarterly at the QI meeting. Appropriate follow-up action will be initiated by the QI committee as necessary.	

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F 241 F 241 SS=D	Continued From page 5 483.15(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, and resident and staff interviews, the facility failed to provide sufficient numbers of mechanical lifts to meet resident needs and maintain dignity during 1 random observations of 2 residents (#8, #27) who required the use of a mechanical lift for transfers. The findings were: Observation on 4/12/16 at 8:50 AM showed residents #8 and #27 had called for assistance. The call light for resident #27 was answered at 8:56 AM and s/he requested assistance to the bathroom. The resident was transferred from the wheelchair to the toilet by CNA #3 and CNA #4 with the use of a sit-to-stand lift. A call light was placed within reach of the resident and the CNAs left. The call light for resident #8 was answered at 9:05 AM and the resident requested to go to bed. The resident was told the two lifts used to transfer residents were both being used and the resident would have to wait. Between 9:02 AM and 9:10 AM, resident #27 was asked two times if s/he was done using the bathroom. After resident #27 was done, the lift was taken to resident #8 at 9:23 AM, 33 minutes after the call light was activated. The resident was transferred to the bathroom and was found to be incontinent of urine. Interview with both residents during the observation revealed	F241 F 241	The facility will 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 will be met as evidenced by: A. All residents who require a mechanical lift could be affected. B. Residents who are in need of a mechanical lift for toileting will be assisted to the toilet in a timely manner. Education will be provided to all nursing assistants on toileting those residents requiring use of a lift in a timely manner. C. A sit to stand mechanical lift was ordered on 4/26/16 for additional availability. The licensed nurse (LN) will observe residents asking to toilet who require a mechanical lift to ensure they are assisted to the toilet in a timely manner. The LN will complete random checks no less than 1 time every shift for 4 weeks and will report the results to the Director of Nursing (DON). Random observations will be done by the DON or designee no less than 3 times every week.	5/29/16

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F 241	Continued From page 6 the facility did not have enough mechanical lifts. Interview with LPN#1 on 4/12/16 at 9:23AM revealed the facility needed additional lifts. Further, the number of residents requiring lifts during transfers had increased but the number of lifts available had not. During a resident group interview on 4/12/16 at 1:30 PM, the residents indicated the facility did not have a sufficient number of lifts to meet the needs of the residents and they were required to wait for care to be provided.	F 241	D. A quality improvement monitoring tool will be implemented by the DON to ensure residents ae toileted in a timely manner. This monitoring will be completed monthly and reported on quarterly at the QI meeting. Appropriate follow-up action will be initiated by the QI committee as necessary.	
F 244 SS=D	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 observation, resident and staff interview, and review of resident council meeting minutes and grievance logs, the facility failed to ensure resolution for 1 of 1 repeated grievances reviewed. The findings were: Review of the 11/16 resident council meeting minutes and the attached grievance log showed residents had inquired about replacing the blinds in the dining room on 4/2/15 (9 months earlier). Further review of the minutes/log showed the administrative staff had been notified. The follow-up to the grievance showed, "Has been discussed, not feasible at this time. Up for	F 244	This facility will ensure that it will listen to the views and act upon the grievances and recommendations of residents and families. This requirement will be met as evidenced by: A.) All residents and family members may be affected. B.) Grievance paperwork has been placed on the information board and is visible and accessible to all residents and family. a.) Social Service Director will ensure the grievance paperwork is readily available. b.) All grievances will be discussed with the person(s) issuing the grievance. c.) appropriate action will be taken as necessary.	5/29/16

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F 244	Continued From page 7 discussion at a later time." The grievance was identified in resident council meeting minutes 2 additional times, on 6/4/15 and 7/2/15. The follow-up comment was, "Staff to manually fix blinds." The following concerns were identified: a. During a resident group interview on 4/12/16 at 1:30 PM, the residents revealed the blinds in the dining room continued to be broken and staff were unable to close the window coverings completely which allowed the sun to shine in on residents while they ate their meals. b Observation on 4/12/16 at 8 AM and 4/13/16 at 7:45 AM showed the East wall of the dining room had widows that covered the length of the room. The vertical blinds on these windows were broken and missing 10-12 slats. c. Interview with the social service director and DON on 4/13/16 at 10AM verified the blinds were in need of repair and the grievance had not been resolved. d. Interview with the maintenance director on 4/14/16 at 8:50 AM verified the maintenance department was behind in the repair work due to vacant positions. He further stated the blinds had been discussed; however, there was nothing ordered at that time.	F 244	d.) Follow-up provided to the person(s) who initiated the grievance. e.) New drapes have been ordered on 4/26/16 and are to be custom made with an estimated delivery date of 6/2/16. C.) A monitoring tool will be developed by the Social Service Director to identify any/all grievances and to monitor follow-up with any/all actions taken to resolve issues. This monitoring tool will be reported on quarterly at the QI meeting	5/29/16
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and review of grievance logs, the	F 253	The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This requirement will be met as evidenced by: A. All resident areas could be affected.	5/29/16

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F 253	Continued From page 8 facility failed to provide maintenance services necessary to ensure a comfortable interior for 2 of 3 resident areas (the dining room, 100 hall). The findings were: 1. Observation on 4/12/16 at 8 AM and 4/13/16 at 7:45 AM showed the East wall of the dining room had widows that covered the length of the room. The vertical blinds on these windows were broken and missing 10-12 slats. Interview with a group of residents on 4/12/16 at 1:30 PM verified the broken blinds were bothersome and had been discussed with staff. Review of the grievance log showed grievances were filed from the resident group on 4/2/15, 6/4/15 and on 7/2/15 related to the blinds, and a resolution had not been reached. 2. Observation on 4/14/16 at 8:50 AM showed the following areas: a. In the bathroom adjacent to the tub room in the 100 hall there was a gouged area in the paint near the toilet. There was also a broken piece of laminate on the front face of a cabinet which was pulling away, and the area where the sink connected to the wall was damaged and cracked. b. The bathroom wall in room 104 had a gouged area 2 feet long by 3 inches wide which exposed the drywall. c. The wall in the bathroom of room 101 had a gouged area with chipped paint. 3. Interview with the maintenance director on 4/14/16 at 8:50 AM verified the maintenance department was behind in the repair work due to vacant positions. He further stated the blinds had been discussed; however, there was nothing ordered at that time.	F 253	B. All rooms will be checked routinely for necessary repairs. a. Windows in the dining area were measured and drapes ordered on 4/26/16. (These drapes do have to be custom made.) The drapes will replace the vertical blinds currently hanging in the dining room. b. The sink in the bathroom adjacent to the tub room where the crack was where it connected to the sink was repaired. 4/15/16. The chip paint area will be removed and the area repainted. c. The bathroom wall in room 104 with the exposed drywall will be repaired and the area repainted. d. The wall in the bathroom of room 101 was spackled on 4/15/16 and will be repainted. C. Maintenance or housekeeping designee will inspect room on a quarterly basis, and as needed or as problems are identified with listed repairs to be completed in a timely manner. D. A monitoring tool will be developed and completed on a quarterly basis with repairs listed for review by the maintenance supervisor. E. This monitoring tool will be completed quarterly by the Designee and will be reported on at the QI meeting. Appropriate follow-up action will be initiated by the QI committee as necessary.	

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F 279	Continued From page 9	F 279	The facility will develop a comprehensive care plan for each resident that includes measureable objectives and timetables to meet a resident's medical, nursing, and psychosocial needs. This care plan will be used to describe the services that are to be furnished to attain or maintain the resident's highest practical well-being. This requirement will be met as evidenced by: A. All residents could be affected. B. All resident's care plans will be reviewed and updated by the Interdisciplinary Team (IDT) to reflect the most current comprehensive assessment. a. Resident #5's care plan was reviewed and updated to reflect both Visual Function and Communication on 4/27/16. b. Resident #14's care plan was reviewed ad updated to address both Psycho-social well-being and Mood State on 4/28/16. C. Assessments will be reviewed annually, quarterly, and with any significant change to ensure that care plan is currently updated to reflect any/all changes that may have occurred. The IDT will be	5/29/16
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 develop care plans in a variety of areas for 2 of 9 sample residents (#5, #14). The findings were: 1. Review of the 6/1/15 significant change MDS assessment showed resident #14 had triggered areas that included Psychosocial Well-being and Mood State. Review of the CAAs for these areas revealed a care plan would be developed. Review of the care plan with a review date of 8/25/16 showed these areas were not addressed.			

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	535019	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONNIE BLUEJACKET MEMORIAL NURSING HOME	388 SOUTH US HWY 20 BASIN, WY 82410

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F 279	Continued From page 10 2. Review of the 10/26/15 admission MDS assessment showed resident #5 had triggered areas that included Visual Function and Communication. Review of the CAAs for these areas showed a care plan would be developed. Review of the care plan last reviewed on 10/20/15 showed visual function and communication needs were not addressed. 3. Interview with the DON on 4/13/16 at 4:05 PM verified these care plans were planned to be developed and she was unsure why they had not been done.	F 279	responsible for these reviews and/or updates to current care plan. The IDT will also communicate these changes to staff at the time changes do occur. D. A monitoring form will be developed by the DON to ensure that annually, quarterly, and with any significant change that the care plan reflects the most current assessment. E. This monitoring tool will be completed monthly by the DON and reported on quarterly at the QI meeting. Appropriate follow-up action will be initiated by the QI committee as necessary.	
F 312 SS=D	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 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, staff interview and review of policies and procedures, the facility failed to ensure adequate perineal care was provided for 2 of 2 residents (#8, #27) observed for incontinence care. The findings were: 1. Observation on 4/12/16 at 8:57 AM showed CNA#3 and CNA#4 transferred resident #27 from the wheel chair to the bathroom with a sit-to-stand lift. The wet incontinence pad was removed and perineal care was provided. CNA#4	F312	F312 A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This requirement will be met as evidenced by: A. All residents who are incontinent could be affected. B. Nursing assistants will be inserviced on how to provide proper perineal care by the DON utilizing the section on "Perineal care (peri-care) from the "Mosby's Textbook for Nursing Assistants". C. The LN will observe individual	5/29/16

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F 312	Continued From page 11 cleaned the resident's posterior perineum and did not clean the anterior perineum and upper thighs where urine had come into contact with skin. Review of the 2/9/16 significant change MDS assessment showed the resident required extensive assistance with toileting and personal hygiene. 2. Observation on 4/12/16 at 9:33 AM showed LPN #1 and CNA #4 transferred resident #8 from the wheelchair to the bathroom. The resident was incontinent of urine. The CNA cleansed the posterior perineum and did not clean the anterior perineum to include the upper thighs where urine had come into contact with the skin. Review of the 3/15/16 significant change MDS assessment showed the resident needed extensive assistance with toileting. 3. During an interview with the DON on 4/14/16 at 9:30 AM, she verified the CNA needed to clean the anterior and posterior perineum as part of incontinence care. 4. Review of the policy and procedure provided by the facility for perineal care, copied from the "Mosby's Textbook for Nursing Assistants" showed "Perineal care (pericare) involves cleaning the genital and anal areas. These areas provide a warm, moist, and dark place for microbes to grow. Cleaning prevents infection and odors, and it promotes comfort."	F 312	Nursing assistants performing perineal care to ensure perineal care is done correctly. LN to provide additional instruction if needed. DON will follow-up with additional instruction and observation of the individual C.N.A. who did not perform perineal care correctly. A. A monitoring tool will be developed by the DON to assess each C.N.A. performing perineal care. B. This monitoring tool will be completed monthly by the DON and reported on quarterly at the QI meeting. Appropriate follow-up action will be initiated by the QI committee as necessary.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISI ON/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323	The facility will ensure that resident's environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistive devices to prevent accidents.	5/29/16

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F 323	Continued From page 12 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and resident and staff interviews, the facility failed to ensure safe transfers for residents (#14, #27) during 2 of 6 resident transfers observed. The findings were: 1. Observation on 4/12/16 at 8:57 AM showed CNA#3 and CNA#4 transferred resident #27 from the wheel chair to the bathroom with the sit-to-stand mechanical lift. The resident held onto the lift handle with the right hand only. The resident was unable to use the left upper extremity. Further, the weight of the resident appeared to be supported by the sling and not the lower extremities, as the resident was leaning back and away from the lift. An interview with the resident that same day at 10:10 AM revealed s/he had difficulty holding onto the lift with the right arm only. Observation of the medication pass at 11:15 AM showed the resident requested pain medication for right shoulder discomfort. Review of the 2/9/16 significant change MOS assessment showed the resident had diagnoses that included cerebral vascular accident. Further, it showed the resident needed extensive assistance with transfers. Interview with the DON on 4/14/16 at 9:30 AM revealed risk management had determined the sit-to-stand lift was to be used to transfer the resident. Further, she indicated the resident had refused the use of other lifts. There was no documentation to show an evaluation for	F 323	A. All residents who require transfers utilizing a mechanical lift could be affected. B. The Risk Manager will assess all residents to determine the amount of assistance required for transfers. a. Resident #14 was assessed for the correct sling size and it was determined that the present sling is the correct size. b. Resident #27 was assessed for the correct mechanical lift and it was determined that he must be changed to a maxi lift (full body) to ensure safety and les stress to his right shoulder. C. Nursing assistants will be in-serviced by the DON on safe transfers for resident requiring a mechanical lift and how to properly apply/use slings. D. LN will observe placement of the sling on resident #14 every shift times four weeks with results provided to the DON. Random observations of proper sling placement will be done by the DON or designee no less than 3 times every week. E. A quality improvement tool will be developed by the DON to ensure that residents are transferred safely. initiated by the QI committee as necessary.	

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F 323	Continued From page 13 safety had been completed. 2. Review of the 6/1/15 significant change MDS assessment showed resident #14 required extensive assistance with transfers. Observation on 4/12/16 at 8:50 AM showed CNA #4 was preparing the resident for a transfer with a full mechanical lift. The sling was positioned under the resident and then the DON came in to assist with the transfer. When the resident was raised off of the wheelchair, the opening in the bottom of the sling allowed the resident to slide down with his/her buttocks and part of the thighs coming through the opening in the sling. The resident verbalized pain and discomfort in the process saying "put me down, it hurts." The aide and the DON continued to transfer the resident to bed. Interview with CNA #4 on 4/12/16 at 9:50 AM verified the sling had not been positioned correctly under the resident so it allowed the resident to slide through the opening more than expected. The aide stated she should have stopped and repositioned the sling to ensure safety and comfort for the resident.	F 323	This monitoring tool will be completed monthly by the DON and reported on quarterly at the QI meeting. Appropriate follow-up action will be initiated by the QI committee as necessary.	
F 386 SS=E	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.	F 386	The physician will review the resident's total program of care including medications and treatments; write, and sign and date all orders at each 60 day required visit. This requirement will be met as evidence by: A. All residents have the ability to be affected. B.The Administrator and the DON will review with the physician	5/29/16

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F 386	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the physician reviewed residents' medication regimen during the 60-day review for 6 of 9 sample residents (#5, #8, #11, #14, #23, #31). The findings were. 1. Review of the physician progress notes dated 1/28/16 and 3/22/16 showed the physician had seen resident #8 for "60-day nursing home rounds." The notes further showed treatment plans for depression and knee pain were reviewed. There was no documentation to show the routine and prn (as needed) medications were reviewed. In addition, the progress notes provided by the facility had not been signed by the physician. 2. Review of the physician progress notes dated 1/28/16 and 3/22/16 showed the physician had seen resident #11 for "Sixty-day nursing home rounds." The plan showed, "Continue current management. No changes at this time." There was no documentation to show the medication regimen was reviewed during the visits. In addition, the notes provided by the facility had not been signed by the physician. 3. Review of the physician progress notes dated 1/28/16 showed the physician had seen resident #23 for "Sixty-day nursing home rounds." The plan showed, "Continue current management. No changes at this time." There was no documentation to show the medication regimen was reviewed during the visit. In addition, the note provided by the facility had not been signed by the physician.	F 386	the requirements as listed above (5/4/16). a. Physician will dictate all 60 day visits to include stated review of all orders to include but not limited to medication and treatment orders in his dictation or to complete the "60 Day Review" document in the EMR (electronic medical record). b. All dictation will be electronically signed by the physician within 5 days of dictation and entry into the computer. c. All resident 60 day progress notes dated 1/28/16 and 3/22/16 will be electronically signed by the physician. Future visits will include indication that all orders have been reviewed and are to continue unless otherwise specified. C. A monitoring tool will be developed by the DON which will be used to review charts after each 60 day physician visit. The areas to be monitored include: dictation will be signed within the 5 day range. The dictation will reflect that orders have been reviewed and are to continue stated in the dictation or the "60 Day Review" document will be completed in the EMR. Any infractions noted by the DON will be brought to the attention	

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F 386	Continued From page 15 4. Review of the physician progress notes dated 1/28/16 and 3/22/16 showed the physician had seen resident #31 for "Sixty-day nursing home rounds." The notes showed the resident's rash and associated skin irritation had been addressed. There was no documentation to show the medication regimen was reviewed during the visit. In addition, the notes provided by the facility had not been signed by the physician. 5. Review of the physician progress notes dated 1/28/16 and 3/22/16 showed the physician had seen resident #14 for "Sixty-day nursing home rounds." The note included an objective examination, assessment, and plan. However, there was no documentation to show the medication regimen was reviewed during the visit. In addition, there was no electronic or written physician signature. 6. Review of the physician progress notes dated 1/28/16 and 3/22/16 showed the physician had seen resident #5 for "Sixty-day nursing home rounds." The note included an objective examination, assessment, and plan. However, there was no documentation to show the medication regimen was reviewed during the visit. In addition, there was no electronic or written physician signature. 7. Interview with the DON on 4/13/16 at 2:20 PM indicated the physician reviewed the electronic MARs during the 60-day visits. However, she confirmed there was no documentation to show the reviews were completed.	F 386	Of the physician for immediate correction. D. This monitoring tool will be completed after each 60 day physician visit and reported on quarterly at the QI meeting. Approved follow-up will be initiated by the QI committee as necessary.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEUSTORE DRUGS & BIOLOGICALS	F431		

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F 431	Continued From page 16 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure expired medications were not available for use in 1 of 3 storage areas (the	F 431	Drugs and biologicals used in the facility will be labeled in accordance with currently accepted professional principles, and include appropriate accessory and cautionary instructions, and the expiration date when applicable. This requirement will be met as evidenced by: A. All medications located in the medication cupboards, medication cart, and the medication refrigerator could be affected. B. a. The Brovana package with the expiration date of 3/16 was removed from the refrigerator and given to the DON for proper disposal 4/14/16. b. All medications in the medication cart, medication cupboards, and the medication refrigerator will be labeled with an easily identifiable expiration date. C. The DON or designee will check the medication cart, the medication cupboards, and the medication refrigerator for expired medications every week when ordering and prn. All medications with an	5/29/16

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F 431	Continued From page 17 medication room).The findings were: Observation of the medication room on 4/14/16 at 8:50 AM showed a box of 12 individual packages of the medication Brovana located in the refrigerator. The date on the packages showed the medication had expired 3/16. Interview with LPN #1 at that time confirmed the medications located in the refrigerator were for resident use and the Brovana had expired and needed to be removed.	F 431	Expiration date for the current month will be pulled from the areas and given to the DON for proper disposal. A monitoring tool will be developed by the DON to ensure all medications are correctly labeled with an expiration date if applicable; D.This monitoring tool will be completed monthly and reported on quarterly at the QI meeting.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility niust establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441	Appropriate follow-up action will be initiated by the QI committee as necessary, F441 The facility will establish and maintain and infection control (IC) program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of transmission of disease and infection. This requirement will be met as evidenced by: A. A policy will be developed to outline an adequate cleaning procedure for all mechanical lifts to include the cleaning as appropriate for the slings as well. B. a. All nursing assistants will be Inserviced on the policy for cleaning the lifts between resident use. b.Disposable sani-wipes will be	5/29/16

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F 441	Continued From page 18 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of policies and procedures, the facility failed to ensure infection control measures were observed during 2 random observations. The findings were: 1. Observation on 4/12/16 at 9:33AM showed the following concerns with infection control: a. Resident#8 was assisted to the bathroom with a sit-to-stand lift. CNA#4 donned gloves and completed perineum care. The CNA then removed her gloves and without cleansing her hands proceeded with additional tasks. The aide assisted the resident with adjusting the glasses, placement of oxygen and removing footwear. b. The aide removed the sling used to transfer the resident and placed it on the lift, then moved the equipment to the storage area located in the hallway. The lift handles used by the resident during the transfer were not cleaned before being placed in the storage area. c. Interview with CNA#5 on 4/13/16 at 2:35 PM revealed lifts were not cleaned between residents unless they were visibly soiled. She also verified the facility had 2 slings for the sit-to-stand	F 441	attached to the mechanical lifts to be used in between resident transfers for cleaning of both the lift parts and/or the slings. c.Slings are to be inspected q shift and and when visibly dirty will be machine laundered. d.Lifts are to be cleaned each night by the nursing assistant with documentation completed and returned to the DON each month. e.DON or designee to do random checks no less than three times q week with documentation given to the DON. f.Nursing assistants will be inserviced on the correction method of passing ice and the importance of washing hands or using hand sanitizer between resident rooms. g. Ice scoop ordered. C.A monitoring tool will be developed by the DON to ensure that the mechanical lifts and the slings are wiped down between resident transfers. A monitoring tool will also be developed to ensure the the nursing assistant on the night shift will wipe the lifts down and inspect the slings and machine launder the slings if visibly soiled. A monitoring tool will be developed to ensure that the nursing assistants when passing ice are using the ice scoop and using proper hand hygiene in between resident room.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 19 mechanical lifts which were shared between 8-9 residents and they were cleaned between uses only if they appeared dirty. 2. Observation on 4/13/16 at 10:20 AM showed CNA#3 provided drinks and ice to residents from a wheeled cart. The CNA retrieved personal mug from resident room #106 and returned to the cart. The aide removed ice from a cooler using a small paper cup and filled the mug with the ice and beverage and returned it to the resident. The paper cup was placed back into the cooler. The aide then went to resident room #107 and retrieved the resident's mug filling it with ice using the same paper cup. The beverage was added and the mug was returned to the resident. The aide continued to pass fluids to the remaining residents in the same manner. During this process the aide did not wear gloves and the paper cup did not prevent her hands from coming into contact with the ice. In addition, the aide did not perform hand hygiene in between handling residents' personal items. 3. Interview with the infection control preventionist on 4/14/16 at 7:55 AM verified hands needed to be cleansed after gloves were removed and before additional care was provided. Further, she acknowledged ice was to be removed from its container using a ice scoop rather than a paper cup. Finally, hands needed to be cleansed between residents after coming in contact with their personal items. Interview with the DON on 4/14/16 at 9:30 AM revealed there was no staff surveillance being done related to hand hygiene that she was aware of. 4. Review of the policy and procedure for "Preventing Infection" showed for "Rules of Hand			

5/10/16

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

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FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEF CIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535019	A. BUILDING _____ B. WING _____	04/14/2016

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F 441	Continued From page 20 Hygiene ...Use an alcohol-based hand rub to practice hand hygiene if they are not visibly soiled. Follow this rule: ...After contact with objects (including equipment) in the person's setting...After removing gloves."	F 441	**F 441** **D. These three monitoring tools will be completed monthly and reported on at the QI meeting quarterly. Appropriate follow-up action will be indicated by the QI committee as necessary.**	