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

PRINTED: 06/10/2016
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
	535030	A. BUILDING _____ B. WING _____	05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZONS CARE CENTER	1111 LANE 12 LOVELL, WY 82431

(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 CAAs- Care Area Assessments CNA- Certified Nurse Aide DON- Director of Nursing Services MDS- Minimum Data Set MAR- Medication Administration Record LPN- Licensed Practical Nurse RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 157 SS=D	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	F 157	The facility will immediately inform the resident's physician, legal representative or interested family member of accidents which result in injury to the residents, significant charges in the resident's physical, mental, or psychosocial states, change in room assignment or decision to transfer or discharge a resident from the facility.	07-10-2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Nicole Schwartz | LNHA | 7.20.16

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.

JUL 20 2016

Spoke c Traci Harrison on 8/4/16 at 4:30pm. Plan accepted c agreed changes. Tina Lamb

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F 157	Continued From page 1 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 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 ensure the physician was notified of a change in condition for 1 of 8 sample residents (#52) who had a change in condition. The findings were: Review of nursing notes from 5/12/16, 5/14/16, and 5/15/16 showed resident #52 had been experiencing urinary symptoms including frequency and urgency. The resident had also experienced 5 falls from 5/12- 5/24/16. Further review showed although documentation included notification to the physician of the falls, there was no evidence the physician was notified of the urinary symptoms. Interview with RN #1 on 5/26/16 at 9:25 AM verified the physician had not been notified of the urinary symptoms.	F 157	A) The facility will ensure the physician is notified related to change in condition of resident #52 and all other residents. B) All nurses will be educated on the importance and procedures of immediately reporting changes in condition to the physician and legal representative/ family member. C) Monitoring of compliance will be done by weekly random review of the "Physicians Round List" by a supervisor using the quality improvement monitoring tool until substantial compliance has been met. D) Nurses not notifying the provider of acute illness will receive immediate in-servicing and corrective action will be taken. E) Results will be reported quarterly as part of the facility Quality Assurance Program.	07-10-2016
F 243 SS=E	483.15(c)(1)-(5) RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP A resident has the right to organize and participate in resident groups in the facility; a resident's family has the right to meet in the facility with the families of other residents in the	F 243	The facility will provide residents or family groups with a private space, staff or visitors attend meetings at the group's invitation, and provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.	07-10-2016

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F 243	Continued From page 2 facility; the facility must provide a resident or family group, if one exists, with private space; staff or visitors may attend meetings at the group's invitation; and the facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings. This REQUIREMENT is not met as evidenced by: Based on review of resident council meeting minutes and policy and procedure, and resident and staff interview, the facility failed to ensure a resident of the nursing home was designated to represent the resident group for 12 of 12 months (May 2015 to April 2016) reviewed. In addition, during this 12 months the facility leadership attended the meetings with no evidence their attendance was requested. The findings were: 1. Review of resident council meeting minutes from May 2015 to April 2016 showed facility leadership staff were present at each meeting. There was no evidence the resident council invited the staff or permission was given for staff to participate. Further, the resident council president was not a resident of the nursing home, but rather a resident of the nearby assisted living facility (ALF). 2. Group interview with 13 residents on 5/24/16 at 2:30 PM revealed resident council meetings always had facility leadership present at meetings and residents wanted the option to meet in private. 3. Interview with the activities director on 5/25/16 at 4:20 PM confirmed leadership staff attended all	F 243	The facility will ensure the resident council president is a resident of New Horizons Care Center. A revised resident council policy will state an employee from a non-biased department will take meeting minutes and be an advocate for residents during resident council. A) A unit secretary will send out meeting minutes to leadership within two days of meeting. B) Leadership will then have one week to send a response to the unit secretary in writing. C) The unit secretary or advocate will read the response at the beginning of the next scheduled resident council meeting. D) Residents will be asked if they would like to invite any leaders for further explanation and final resolution. E) Quality monitoring of resident council minutes will be done weekly by non-biased advocate using the quality improvement monitoring tool until substantial compliance has been met. F) Results will be reported quarterly as part of the facility Quality Assurance Program.	

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F 243	Continued From page 3 meetings and the president of the resident council was a resident from the ALF. Further, the director confirmed the current president did not represent the nursing home residents well and a change was needed. She also stated leadership attended meetings in order to resolve concerns or grievances. 4. Review of the facility policy titled "Resident Council" revised on 6/30/11 showed "...3. A resident member will be designated to act as spokes person/chairman...6...Family members, the ombudsman, visitors and facility personnel may attend only at the request or invitation of the resident council..."	F 243		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, policy and procedure review, and review of resident council meeting grievances, the facility failed to ensure resolution for repeated grievances during 3 of 3 months (February 2016, March 2016, April 2016) reviewed. The findings were: 1. Review of resident council meeting minutes dated 2/18/16 showed residents voiced concerns about staff not stating their names and being rude	F 244	The facility will 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. A) The current grievance policy will be implemented for families to utilize and ensure grievances are addressed. B) Past resident grievances are reviewed and addressed. C) Current residents will be educated in the July 2016 resident council meeting and annually. Families will receive information in the newsletter. D) Staff will be educated on the grievance policy at the July 2016 staff meeting and annually.	07-10-2016

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F 244	Continued From page 4 while providing cares. 2. Review of resident council meeting minutes dated 3/17/16 showed no evidence of resolution to concerns voiced at previous meetings. Further, the residents voiced concerns about the facility not having enough CNAs. 3. Review of resident council meeting minutes dated 4/21/16 showed no evidence of resolution to concerns voiced at previous meetings. Further, the residents expressed concerns with nursing communication about medications, changes in care, call lights not being answered, and beds not being made. 4. Group interview with 13 residents on 5/24/16 at 2:30 PM revealed concerns with staff not communicating changes in care, call lights not being answered timely, staff being short tempered and rude, and not enough staff. 5. Interview with the activities director on 5/25/16 at 4:20 PM revealed the facility did not have a formal grievance/complaint process in effect. 6. Review of the facility policy titled "Resident Council" revised on 6/30/11 showed "...2. Within the council forum, members are provided with the opportunity to express any concerns and or grievances, contribute ideas and make recommendations regarding the facility's functions. Residents may discuss likes, dislikes, things they would like to do and things they would like to change. 3. Each department is provided with a record of the resident's concerns in order to provide assistance and respond to requests. 4. Responses, follow-ups, or any plan regarding documented concerns from the council.	F 244		

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F 244	Continued From page 6 Responses are indicted [sic] in writing and are to be read at the next resident council meeting in order to determine resolution."	F 244		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	The facility will conduct initially and periodically a comprehensive, accurate standardized, reproducible assessment of each resident's functional capacity. A) The facility will make a comprehensive assessment of the resident's needs using the RAI process, for residents #6, #11, #17, #29, #39, #44, #47, #52, #59, #61 and all other residents. B) All staff members responsible for completing the CAA's will be educated on the CAA process and the procedure to complete the CAA with thorough, accurate data. C) Monitoring of compliance will be done by weekly random review of one comprehensive assessment and CAA by the MDS Coordinator using the quality improvement monitoring tool until substantial compliance has been met. D) Staff members responsible for CAA completion that do not complete them according to the CAA process with thorough accurate data will receive immediate in-service and corrective action will be taken. E) Results will be reported quarterly as part of the facility Quality Assurance Program.	07-10-2016

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F 272	Continued From page 6	F 272		

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interview, the facility failed to ensure comprehensive assessments were completed in a variety of areas for 10 of 13 sample residents (#6, #11, #17, #29, #39, #44, #47, #52, #59, #61). The findings were:

1. Review of the 10/27/15 significant change MDS assessment for resident #17 showed areas that triggered for comprehensive assessment included: Cognitive loss/dementia, Communication, Falls, Nutrition, and Pressure ulcers. Review of the CAAs for these triggered areas showed the problem was not well defined, and although the causes and risk factors were shown, there were no conclusions drawn or evidence the data was analyzed to support the care plan decision.

2. Review of the 5/11/16 significant change MDS assessment for resident #6 showed areas that triggered for comprehensive assessment included: Cognitive loss/dementia, Communication, Falls, Pressure ulcers, and Psychotropic drug use. Review of the CAAs for these triggered areas showed the problem was not well defined, and although the causes and risk factors were shown, there were no conclusions drawn or evidence the data was analyzed to support the care plan decision.

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F 272	Continued From page 7 3. Review of the 5/12/16 significant change MDS assessment for resident #52 showed areas that triggered for comprehensive assessment included: Falls, Nutrition, Psychotropic drug use, Communication and Visual function. Review of the CAAs for Psychotropic drug use, Communication and Visual function showed the CAAs were not completed and there was no information. The other area CAAs showed the problem was not well defined, and although the causes and risk factors were shown, there were no conclusions drawn or evidence the data was analyzed to support the care plan decision. 4. Review of the 12/22/15 annual MDS assessment for resident #61 showed areas that triggered for comprehensive assessment included: ADL functional/rehabilitation potential, Urinary incontinence, Behavioral symptoms, Falls, Nutritional status, Pressure ulcers, Psychotropic drug use, and Pain. Review of the CAAs for these areas showed an analysis of data to support the care plan decision was lacking. 5. Review of the 6/2/16 annual MDS assessment for resident #44 showed areas that triggered for comprehensive assessment included: Visual function, ADL functional/rehabilitation potential, Urinary incontinence, and Nutritional status. Review of the CAAs for these areas showed an analysis of data to support the care plan decision was lacking. 6. Review of the 6/30/15 significant change MDS assessment for resident #11 showed areas that triggered for comprehensive assessment included: Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Pressure Ulcer, Psychotropic Drug Use, and Pain. Review	F 272		

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F 272	Continued From page 8 of the CAAs for these triggered areas showed the problem was not well defined, and although the causes and risk factors were shown, there were no conclusions drawn or evidence the data was analyzed to support the care plan decision. 7. Review of the 9/22/15 significant change MDS assessment for resident #39 showed areas that triggered for comprehensive assessment included: ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Dental Care, Pressure Ulcer, Psychotropic Drug Use, and Pain. Review of the CAAs for these triggered areas showed the problem was not well defined, and although the causes and risk factors were shown, there were no conclusions drawn or evidence the data was analyzed to support the care plan decision. 8. Review of the 1/16/16 admission MDS assessment for resident #59 showed areas that triggered for comprehensive assessment included: ADL function, Urinary incontinence, Falls, Nutrition, Psychotropic drug use, and Pain. Review of the CAAs for these triggered areas showed the problem was not well defined, and although the causes and risk factors were shown, there were no conclusions drawn or evidence the data was analyzed to support the care plan decision. 9. Review of the 9/1/15 annual MDS assessment for resident #47 showed areas that triggered for comprehensive assessment included: Cognitive loss/dementia, Communication, ADL function, Behaviors, Activities, Falls, Nutrition, Dental care, Pressure ulcers, and Pain. Review of the CAAs for these triggered areas showed the problem was not well defined, and although the causes	F 272		

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F 272	Continued From page 9 and risk factors were shown, there were no conclusions drawn or evidence the data was analyzed to support the care plan decision. 10. Review of the 12/22/15 annual MDS assessment for resident #29 showed areas that triggered for comprehensive assessment included: Cognitive loss/dementia, Communication, ADL function, Urinary incontinence, Psychosocial well-being, Activities, Falls, and Pressure ulcers. Review of the CAAs for these triggered areas showed the problem was not well defined, and although the causes and risk factors were shown, there were no conclusions drawn or evidence the data was analyzed to support the care plan decision. 11. Interview with the MDS coordinator on 5/26/16 at 11:15 AM verified the CAAs were completed by staff in various departments. The coordinator stated she had training related to the Resident Assessment Instrument (RAI) process which included the CAAs; however, the other staff who completed areas had not. She verified the information in the analysis of some CAAs were not comprehensive and lacked adequate information and analysis.	F 272		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the	F 280	The facility will develop a comprehensive care plan within seven days with completion of the comprehensive assessment, prepared by our interdisciplinary team, including the physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	07-10-2016

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F 280	Continued From page 10 comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to update care plans as resident needs changed for 3 of 13 sample residents (#39, #52, #59). The findings were: 1. Review of the 3/23/16 quarterly MDS assessment for resident #39 showed the resident was frequently incontinent of bladder and required the extensive assistance of 1 person for toilet use. Review of the "Risk for skin breakdown r/t [related to] urinary incontinence" care plan, dated 10/22/13 and last reviewed 1/20/16, showed "1. Toilet every 2-3 hours and per resident request or need...5. Limited to extensive assist..." The following concerns were identified: a. Observation on 5/24/16 beginning at 10:20 AM showed the resident was in bed, asleep. At 10:30 AM, CNA #1 and CNA #2 entered the resident's room and prepared to get the resident up for the day. CNA #2 stated the resident liked to sleep late in the morning and frequently didn't get up for breakfast. The resident was transferred	F 280	A) A comprehensive care plan has been developed for resident #39, related to toileting, residents #52 and #59 related to falls and all other residents. B) All nursing staff and the MDS team will be educated on the importance and procedures of updating care plans appropriately with new information to keep the plan current. C) Monitoring of compliance will be done by weekly random review of two care plans by the MDS Coordinator, assessing for accuracy of current functional status, using the quality improvement monitoring tool until substantial compliance has been met. D) Any staff member not completing and updating the care plans will receive immediate in-service and corrective action will be taken. E) Results will be reported quarterly as part of the facility Quality Assurance Program.	07-10-2016

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F 280	Continued From page 11 from bed directly to wheelchair with the use of a full-body lift. CNA #1 stated she had just checked the resident for incontinence "a minute ago" and the resident was dry at that time. The resident was not toileted or offered the opportunity to use the toilet. The resident was dressed while in the wheelchair and then taken out to the dining room. b. Interview with the resident care coordinator on 5/26/16 at 11:20 AM revealed the resident's bladder function had declined since the last MDS assessment. Further, the resident no longer used a sit-to-stand lift due to leg weakness, and was now being transferred with a full body lift. They confirmed the resident's care plan did not accurately reflect the resident's needs related to toileting. 2. Review of the nursing notes and the fall review/investigation reports showed resident #52 had 5 falls in the month of May 2016 (5/12, 5/17, 5/22, 5/23, and 5/24). Review of the fall risk care plan showed a problem date of 5/12/15. The interventions to prevent falls were ensuring access to a walker at all times, ensuring the room was clutter free, and assistance with ADLs especially "personal hygiene and bathing and toileting." The last date the care plan was reviewed was 2/10/16 and there were no additions or updates made since the falls in May 2016. 3. Review of the nursing notes and the fall review/investigation reports showed resident #59 had 10 falls between February 2016 and May 2016 (2/12, 2/25, two falls on 2/26, 3/8, 3/20, 3/29, 4/7, 4/30, 5/4). Review of the fall risk care plan showed a problem date of 1/13/16. The interventions to prevent falls were for staff to know resident's whereabouts, provide frequent	F 280		

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

PRINTED: 06/10/2016
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F 280	Continued From page 12 rounding, use walker/scooter, and help with ADLs as needed. The last date the care plan was reviewed was 4/14/16 and there were no additions or updates made related to the falls in April and May 2016. 4. Interview with the DON and RN #1 on 5/26/16 at 9:40 AM verified the fall reviews and investigations did not always include new interventions/recommendations. In addition, the care plans were not reviewed or updated to reflect changes when falls occurred.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of facility guidelines, the facility failed to ensure neurological assessments were completed as necessary for 1 of 2 sample residents (#59) who experienced falls. The findings were: 1. Review of the nursing notes and the fall review/investigation reports showed resident #59 had 10 unwitnessed falls between February 2016 and May 2016 (2/12, 2/25, two falls on 2/26, 3/8, 3/20, 3/29, 4/7, 4/30, 5/4). Review of neurological	F 309	This facility will ensure each resident receives 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. A) The facility will ensure neurological assessments are completed for all residents who have falls requiring neurological assessments. Neurological assessments were also performed on Res #59. B) All nurses will be educated on the importance of completing neurological assessments on all unwitnessed falls. C) Monitoring of compliance will be done by weekly random review of all fall investigation forms by supervisors using the quality improvement monitoring tool until substantial compliance has been met. D) Nurses not completing neurological assessments will receive immediate in-servicing and corrective action will be taken. E) Results will be reported quarterly as part of the facility Quality Assurance Program.	07-10-2016

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F 309	Continued From page 13 assessments showed there were no neurological assessments completed except for the falls on 3/29, 4/7, and 4/30. Further, the neurological assessment for the fall on 3/29 was incomplete with no assessments being performed during the day or evening shift on 3/30 and no assessments being performed on the day, evening or night shift on 3/31. 2. Review of the facility's undated "Guidelines for Charting" showed "...Falls:...Check neuros [neurological] for head injury q [every] 30 minutes X [times] 4, q hour X 3, q 4 hours X 3, then q shift to finish the 72 hours (day, eve [evening], noc [night]." 3. Interview with the DON, RN#1, and RN #2 on 5/26/16 at 9:45 AM revealed a neurological assessment should have been completed on all unwitnessed falls because the falls could result in an injury that is not seen. Further, the resident had confusion and may not be aware of a head injury.	F 309	This facility will ensure a resident with limited range of of motion receives appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion. A) The facility will ensure restorative treatment plans are being met for resident #17, #39 and all other residents. B) Restorative staff will be educated on the importance of ensuring restorative plans are met and documentation is complete. C) Monitoring of compliance will be done by weekly random review of four restorative plans by the restorative nurse using the quality improvement monitoring tool until substantial compliance has been met. D) Restorative staff not completing restorative assessments will receive immediate in-servicing and corrective action will be taken. E) Results will be reported quarterly as part of the facility Quality Assurance Program.	07-10-2016
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff	F 318		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 318	Continued From page 14 interview, the facility failed to ensure restorative nursing services were provided as planned for 2 of 3 sample residents (#17, #39) with range of motion (ROM) limitations. The findings were: 1. Review of the April and May 2016 restorative care flow records showed the treatment plan and frequency were not being met for resident #17. Review of the 4/13/16 quarterly MDS assessment showed the resident had ROM limitations on one side of the lower extremities. The plan showed the resident was to receive services daily which included maintaining and increasing strength in the lower extremities The following concerns were identified: a. Review of the April 2016 record showed the plan was completed on 4/19, and 4/21. The resident was marked as refusing on 4/5 and 4/22. b. Review of the May 2016 record showed the plan had not been completed any day from 5/1 through 5/25/16. There were two refusals marked for that time frame. 2. Review of the March and April 2016 restorative care flow records showed the treatment plan and frequency were not being met for resident #39. Review of the resident's care sheet showed "Restorative: 2-3x [times] week Maintain mobility Therabands and possible weights - stand up at rail with w/c [wheelchair] behind." The following concerns were identified: a. Review of the March 2016 "Restorative Care Flow Record" showed the resident received "UE/LE [upper extremity/lower extremity] protocol" only 4 times during the month. Further, the resident was supposed to receive "Stand up exercise" 2-3 times a week, and there was no indication the resident received this exercise at any time during the month.	F 318	D) Restorative staff not completing neurological assessments will receive immediate in-servicing and corrective action will be taken. E) Results will be reported quarterly as part of the facility Quality Assurance Program.	

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F 318	Continued From page 15 b. Review of the April 2016 "Restorative Care Flow Record" showed the resident did not receive "UE/LE protocol" or "Stand up exercise" at any time during the month. 3. Interview with RN #2 on 5/26/16 at 10:20 AM verified the restorative nursing service plans were not always completed. She verified there were times when the staff were required to work performing other duties. Additionally, the nurse stated the staff had discussed the importance of ensuring the documentation was completed related to services provided as well as refusals.	F 318		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of manufacture instructions, and medical record review, the facility failed to ensure fall review/investigations were completed and/or timely for 2 of 5 sample residents (#52, #59) with falls. This failure resulted in actual harm for 1 resident (#59). In addition, the facility failed to ensure 1 of 4 observations of lift transfers were done safely which affected resident #47. The findings were:	F 323	The facility will ensure the environment as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. A) The facility will ensure fall investigations are completed on residents #52, #59 and all other residents. In addition the facility will ensure lift transfers are done safely with residents #47 and all other residents. B) All nursing staff will be educated on the importance and procedures of completing fall reports and intervention sheets and updating care plans with new interventions. In addition, all staff will be educated on appropriate lift procedures. C) Monitoring of compliance will be done by weekly review of incident/fall reports by the fall team for: 1. Appropriate interventions 2. Interventions followed through to care plans 3. Interventions put in place In addition restorative nurse will observe one random lift transfer per week. D) Staff not completing fall reports, or putting interventions in place or updating care plans will receive immediate in-service and corrective action will be taken. In addition, staff not following appropriate lift procedures will receive immediate in-service and	07-10-2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 323	Continued From page 16 1. Review of the 4/16/16 quarterly MDS showed resident #59 had diagnoses that included hypertension, pneumonia, hypoxemia, sleep apnea, and Alzheimer's dementia. The resident was independent with ADLs and had a brief interview for mental status (BIMS) score of 12 which indicated moderate impairment. Review of nurses notes showed the resident had falls on 2/12/16, 2/25/16, 2 falls on 2/26/16, 3/8/16, 3/20/16, 3/29/16, 4/7/16, 4/30/16, and 5/4/16. Review of the 1/13/16 fall risk care plan with a review date of 4/14/16 showed the interventions to prevent falls were for staff to know the resident's whereabouts, to provide frequent rounding, ensure the resident used a walker/scooter, and to help with ADLs as needed. The fall on 3/29/16 resulted in a fracture of the resident's right fibula. The following concerns were identified: a. Review of the fall review for the 3/29/16 fall showed the resident was found on the floor of his/her bathroom. The fall review showed there had been 4 falls in the last month. The interventions in place at the time of the fall were: clutter free environment, call light in reach, frequent observations, good lighting, and appropriate footwear. The fall review showed there were major injuries sustained from this fall which included a fractured right fibula. Recommendations on the fall review showed "remind resident to call for help." However, it was also noted the resident "doesn't like to ask for help." The date of the fall team investigation was 4/4/16, 6 days after the fall, and there was no evidence the fall team analyzed the details of this fall and previous falls to determine meaningful interventions. There were no recommendations made by the team, and review of the care plan failed to show any changes were made related to	F 323	corrective action will be taken. E) Results will be reported quarterly as part of the facility Quality Assurance Program.	

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F 323	Continued From page 17 fall prevention. b. Review of the 2/12/16 fall review showed the resident was found on the floor of the room. The fall review showed there had been no falls in the last month. The interventions in place at the time of the fall were: clutter free environment, good lighting, and call light within reach. The fall review further showed there were no injuries, a restorative plan was initiated, and the resident was educated on wearing his/her oxygen. The date of the fall team investigation was 2/22/16, 10 days after the fall, and there were no recommendations or care plan updates related to this fall investigation. c. Review of the 2/25/16 fall review showed the resident was opening the door, got dizzy, and fell. The fall review showed there had been no falls in the last month. However, review of nursing notes showed a fall occurred on 2/12/16. The interventions in place at the time of the fall were: clutter free environment, good lighting, and good footwear. The fall review further showed there were no injuries and the resident was educated on wearing his/her oxygen. The date of the fall team investigation was 2/29/16, 4 days after the fall and the resident had fallen 2 additional times prior to this fall review. Further, there were no recommendations or care plan updates related to the fall teams findings/review. d. Review of the 2/26/16 fall review showed at 2 AM the resident was found on the floor of the room. The fall review showed there had been no falls in the last month. However, review of nursing notes showed falls on 2/12/16, 2/22/16 and 2/25/16. The interventions in place at the time of the fall were: clutter free environment, appropriate footwear, and frequent observations. The fall review further showed there were minimal injuries and the resident was educated on calling for	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 323	Continued From page 18 assistance when experiencing dizziness and unsteadiness. The date of the fall team investigation was 2/29/16, 3 days after the fall, and the team did not make recommendations or care plan updates related to this fall investigation. e. Review of the 2/26/16 fall review showed another fall occurred this day at 2:45 AM. The resident was found on the floor of the room. The fall review showed there had been no falls in the last month. However, according to nursing notes, this was the second fall this day, and there were 3 falls earlier in the month (2/12, 2/22, 2/25). The interventions in place at the time of the fall were: clutter free environment, call light in place, and frequent observations. The fall review further showed there were no injuries and the resident was educated and sent to the emergency room. The date of the fall team investigation was 2/29/16, 3 days after the fall, and there were no recommendations or care plan updates related to the team's fall investigation. f. Review of the 3/8/16 fall review showed the resident stated s/he fell off the toilet. The fall review showed there had been 4 falls in the last month. The interventions in place at the time of the fall were: good lighting, good footwear, and frequent observations. The fall review further showed there were minimal injuries and the resident was seen by the physician, continues to be independent, refuses restorative, and labs were ordered. The date of the fall team investigation was 3/21/16, 13 days after the fall, and there were no recommendations or care plan updates related to the team's fall investigation. g. Review of the 3/20/16 fall review showed the resident was found on the floor of his/her room, had been ambulating and stated his/her legs became weak. The fall review showed there had been 4 falls in the last month. The	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 323	Continued From page 19 interventions in place at the time of the fall were: light source on and call light within reach. The fall review further showed there were no injuries and the physician was notified, labs were drawn, and rapid flu swab and duo nebs were ordered for pneumonia. The date of the fall team investigation was on 3/21/16, and there were no recommendations or care plan updates related to this fall investigation. h. Review of the 4/7/16 fall review showed the resident was found on the floor of room after sneezing. The fall review showed there had been 3 falls in the last month. The interventions in place at the time of the fall were: good footwear, clutter free environment, and frequent observations. The fall review further showed there were minimal injuries and the resident was reminded to use the call light. The date of the fall team investigation was 4/11/16, 4 days after the fall, and there were no recommendations or care plan updates related to this fall investigation. i. Review of the 4/30/16 fall review showed the resident was found on the floor in his/her room after using the toilet. The fall review showed there had been 3 falls in the last month. The interventions in place at the time of the fall were: good footwear, call light in reach, appropriate lighting, frequent observations, and resident instructed. There was not further information on what the resident was instructed for. The fall review further showed there were minimal injuries that included a laceration above the eye. Recommendations on the review showed staff felt the resident was "hungover" as family provided beer and the resident drank "several" prior to the beer being removed. The date of the fall team investigation was 5/2/16, 3 days after the fall, and the recommendation was to ask family not to bring beer to the resident's room.	F 323		

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

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F 323	Continued From page 20 Further, there were no care plan updates related to these recommendations. j. Review of the 5/4/16 fall review showed the resident was found on the floor of room after ambulating in room. The fall review showed there had been 5 falls in the last month. The interventions in place at the time of the fall were: appropriate footwear, call light in place, frequent observations, and light source on. The fall review further showed there were no injuries and the resident refused his/her oxygen. The date of the fall team investigation was 5/16/16, 12 days after the fall, and the fall was reviewed with the physician and orders were received to reduce oxycodone and limit the resident to 2 beers after 2 PM. Review of the care plan failed to show these recommendations were included to help prevent further falls. k. Interview with the DON, RN #1, and RN #2 on 5/26/16 at 9:45 AM revealed the resident was becoming more confused and having increased falls. Further, they verified when the team reviewed the details of the falls, recommendations were not always made. In some cases, the DON felt some interventions that may have been tried were not documented on the care plan. 2. Review of nurses notes showed resident #52 had falls on 5/12/16, 5/17/16, 5/22/16, 5/23/16, and 5/24/16. Review of the fall risk care plan showed a problem date of 5/12/16. The interventions to prevent falls were ensuring access to a walker at all times, ensuring the room was clutter free, and assistance with ADLs especially "personal hygiene and bathing and toileting." The last date the care plan was reviewed was 2/10/16. The following concerns were identified:	F 323		

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

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F 323	Continued From page 21 a. Review of the fall review for the 5/12/16 fall showed the resident attempted to transfer him/herself to the bathroom. The fall review showed there had been no falls in the last month. The interventions in place at the time of the fall were: bed in low position, clutter free environment, appropriate footwear, and frequent observations. The fall review further showed there were no injuries, and no new interventions initiated by staff at the time of fall. The date of the fall team investigation was 5/16/16 and there were no recommendations or care plan updates related to this fall investigation. b. Review of the 5/17/16 fall review showed there had been no falls in the last month. Although review of nursing notes showed a fall occurred on 5/12/16. The resident had attempted to self transfer out of the wheelchair and was found on the floor in the front hallway. There were no injuries noted. There were no new interventions put in place at the time of the fall, and the date of the investigation was shown to be 5/23/16, 6 days after the fall. There were no care plan updates or recommendations made. c. Review of the 5/22/16 fall review showed there had been no falls in the last month, although nursing notes showed 2 falls in the month (5/12, 5/17). The resident had attempted to self transfer to the bathroom and was found on the floor. There were no injuries noted and neuro checks were completed. Recommendations/interventions initiated at the time of the fall included more frequent toileting. The date of the investigation was shown to be 5/23/16 with no care plan update or recommendations made. d. Review of the 5/23/16 nurse's note timed at 12:54 PM showed the resident was found on the floor by the toilet. At that time the resident	F 323		

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

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F 323	Continued From page 22 complained of groin pain. The note further showed the resident did not have any bruising or other complaints of pain and nursing would continue to monitor. The physician and family were notified. There was no investigation notes provided and there was no evidence of updates or review to the care plan. e. Review of the 5/24/16 nurse's note showed the resident was found on the floor of his/her room. There were no injuries noted. There was no additional documentation related to this fall provided. 3. Interview with the DON and RN #1 on 5/26/16 at 9:40 AM verified the fall reviews and investigations did not always include new interventions/recommendations and the care plans were not reviewed or updated to reflect changes with each fall. 4. Observation on 5/24/16 at 10:21 AM showed CNA #3 and CNA #4 transferred resident #47, with an "EZ Way Smart Stand" mechanical lift, from the resident's wheelchair to the toilet. The lifting device used a sling system that was placed behind the resident and secured around the resident's trunk. When the resident was placed on the toilet, CNA #3 locked the lift brakes. At 10:28 AM CNA #3 stated "Yesterday [s/he] almost fell out." The CNAs left the room at that time, leaving the resident secured to the lift with the brakes locked. At 10:36 AM, 8 minutes later, the CNAs returned to the room, unlocked the lift brakes, and assisted the resident off the toilet. The following concerns were identified: a. Review of the "EZ Way Smart Stand" lift instructions received from the facility on 5/26/16 at 11 AM showed "...Safety notes...The only time you should lock the wheels of the EZ Way Smart	F 323		

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

PRINTED: 06/10/2016
FORM APPROVED
OMB NO. 0938-0391

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F 323	Continued From page 23 Stand when in use is when raising or lowering a patient during ambulation. Refer to the instructions for using the EZ Way Smart Stand for ambulation on page 7..." b. Interview with the DON, RN #1, and RN #2 on 5/26/16 at 9:45 AM revealed resident #47 had a cognitive deficit and anyone with a cognitive deficit would not be safe to be left unattended while attached to the lift.	F 323		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and review of the menu and recipe, the facility failed to ensure the food was palatable for 1 of 1 meal tested (5/25/16 noon meal). The findings were: Interview with a group of 13 residents on 5/24/16 at 2:30 PM revealed concerns with the palatability of the food. Review of the menu for the noon meal on 5/25/16 showed "grilled chicken, new potatoes, marinated vegetable salad, and broccoli cheese soup." The following concerns were identified: a. Observation at 11:10 AM of food on the steam table in the kitchen showed the chicken appeared stark white with no browning or seasoning.	F 364	The facility will ensure that each resident receives food prepared by methods that conserve nutritive value, flavor and appearance and food that is palatable attractive and at the proper temperature. A)The dietary manager will ensure that the preparation of meals are done according to the recipe. The dietary manager will ensure that the meals will be served at the appropriate temperature and is palatable. B)All dietary staff will be educated on the importance of food palatability, food temperature, and food preparation. C)Monitoring of compliance will be done by weekly random rounds. The dietary manager will monitor by random rounds: 1. Food preparation 2. Food palatability 3. Food temperature D)Dietary staff producing meals that are not palatable, at proper temperature, or following recipe will receive immediate in-service and corrective action will be taken. E)As part of the dietary manager's quality improvement plan, and report to the Quality Assurance Committee quarterly.	07-10-2016

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F 364	Continued From page 24 b. A test of the meal was done at 12:17 PM after the residents were served in the 3/4 pod. The registered dietitian (RD) was present and the temperature of the chicken was shown to be 104.9 degrees Fahrenheit (F), the potatoes were 107.2 degrees F, and both were cool in temperature when tasted. In addition, the chicken had no seasoning and had little flavor. c. Interview with the RD at that time verified the chicken had been steamed rather than grilled, and there was no seasoning. The RD also tasted the food and verified the temperature was not palatable. d. Review of the recipe for the "Grilled Chicken" showed black pepper was a listed ingredient and the instructions showed "1. Season chicken and grill...2. Hold at 140 F or higher for service..."	F 364		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure residents who had a need for positioning to facilitate independent eating were properly positioned during meals for 1 of 1 sample residents (#39) with such needs. The findings were: Observation of the mid-day meal on 5/24/16 beginning at 11:57 AM showed resident #39 was seated in a wheelchair in the dining room. The	F 369	This facility will ensure it provides special eating equipment and utensils for residents who need them. A) The facility will ensure resident #39 and all other residents receive proper positioned and/or eating utensils during meal times. B) Care plan will be reviewed and updated to reflect therapy recommendations. C) All staff will be educated on reviewing therapy recommendations and following through. D) Monitoring of compliance will be done by weekly random review of two therapy consults using the quality improvements monitoring tool until substantial compliance has been met. E) Staff not following therapy recommendations will receive immediate in-servicing and corrective action will be taken. F) Results will be reported quarterly as part of the facility Quality Assurance Program.	07-10-2016

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 369	Continued From page 25 resident's meal was delivered at 12:05 PM. The resident's wheelchair was positioned far enough away from the table that the resident could not rest his/her elbow on the table. The resident was observed to attempt to use a fork to bring bites of food to his/her mouth; however, the resident was frequently able to bring the fork only to within approximately 4 inches of his/her mouth. After several attempts to get the bites of food into his/her mouth, the resident gave up and set the fork down. Staff were observed to occasionally use a hand under hand method to assist the resident with getting bites of food into his/her mouth, but the resident continued to struggle throughout the meal. Observation of the mid-day meal on 5/25/16 beginning at 12:05 PM showed the resident was seated in a wheelchair in the dining room. The resident's meal was delivered at 12:08 PM. The resident was again observed to have difficulty in getting bites of food on a fork all the way to his/her mouth. At 12:18 PM, the nurse moved the resident in the wheelchair closer to the table, after which the resident was better able to get bites of food to his/her mouth by bracing his/her elbow on the tabletop. At 12:44 PM the resident had independently consumed the entire meal. Review of the medical record showed an occupational therapy discharge note dated 3/31/16 that revealed "...The patient also shown to be independent with the use of the right hand with feeding [him/herself], with correct positioning and propping of the right arm on a firm surface, that is the forearm, before eating. The patient is able to achieve this task following sit-up, that is staying in the chair and feeding [him/herself] with the right arm with minimal tremor..."	F 369		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 369	Continued From page 26 Interview with certified occupational therapist assistant (COTA) #1 on 5/26/16 at 10:15 AM revealed the resident needed proper positioning in order to feed him/herself effectively. Due to the resident's tremors, s/he needed to be positioned close to the dining table in order to brace his/her elbow or forearm on the table. The COTA stated the facility practice was for the occupational therapist to make recommendations, train the resident, and communicate the residents needs to the nursing supervisor. Review of the resident's care plan failed to show the resident required any special positioning in order to eat effectively. Interview with the DON and RN #2 on 5/26/16 at 10:29 AM revealed they were not aware of any specific positioning needs for the resident, and there was an issue with communication between the therapists and the nursing staff.	F 369		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371	The facility will ensure food is: 1. Procured from sources approved or considered satisfactory by Federal, State or local authorities. 2. Stored, prepared, distributed, and served under sanitary conditions according to Food Code 2013 U.S. Public Health Service: 4-601.11.	07-10-2016

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

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F 371	Continued From page 27 Based on observation, staff interview and review of cleaning information, the facility failed to ensure sanitary conditions in 1 of 1 kitchen. The findings were: Observation on 5/25/16 at 10:45 AM showed the following equipment which was in need of cleaning: a. The counter where the electric slicer was stored had a build-up of food debris. b. The interior fans in both walk-in refrigerators #1 and #2 had build-up of black dust on the fans and the surrounding condenser units and ceilings. c. The ice machine located in the kitchen had a build-up of a pink substance. The build-up was on an interior plastic part which came into direct contact with the ice in the bin. Review of the cleaning information showed the machine was cleaned and inspected by the maintenance department on 4/15/16. d. The small stand mixer was observed to not be well cleaned and had dried food in the crevices of the equipment. The mixer was not in use at the time of the observation. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." Interview with the dietary manager on 5/25/16 at 2:25 PM verified the need for additional cleaning on these items. She also stated the maintenance department would need to be contacted more frequently when items in the kitchen were in need of their maintenance/cleaning.	F 371	A) a. The counter where the electric slicer was stored has been cleaned. b. The interior fans in both walk-ins refrigerators #1 and #2 and the surrounding condenser units and ceilings have been cleaned. c. The ice machine in the kitchen has been cleaned. d. The small stand mixer has been cleaned. B) The dietary manager will monitor by weekly random rounds the cleanliness of the entire kitchen including: 1. The counter where the slicer is stored 2. The interior fans in both walk-in refrigerators and surrounding condenser units and ceilings 3. Ice machines 4. The small stand mixer C) All dietary staff will be educated on the importance of distributing and serving food under sanitary conditions. D) Staff distributing and serving food not under sanitary conditions will receive immediate in-servicing and corrective action will be taken. E)As part of the dietary manager's quality improvement plan and report to the Quality Assurance Committee quarterly.	

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F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in 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, staff interview, review of	F 431	The facility will ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles and include the expiration date when applicable. A) The facility will ensure pod 3 and 4 and all other pods have medications that are labeled with expiration dates. B) All nurses will be educated on the importance of labeling medications when available for use. C) Monitoring of compliance will be done by weekly random review of two medication storage areas for labeled medications using the quality improvement monitoring tool until substantial compliance has been met. D) Nurses not labeling medications with expiration dates will receive immediate in-servicing and corrective action will be taken. E) Results will be reported quarterly as part of the facility Quality Assurance Program.	07-10-2016

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 431	Continued From page 29 the manufacturer's instructions, and review of the staff meeting minutes, the facility failed to ensure medications were labeled with the expiration dates once opened in 1 of 4 medication carts (pod 3/4 cart). In addition, the facility failed to ensure the medications available for resident use were not being used past the manufacturer's recommended expiration dates. The findings were: 1. Observation on 5/26/16 at 9:45 AM showed the medication cart for pods #3 and #4 had 1 Humalog KwikPen and 1 Lantus SoloStar pen opened and available for use. Further review showed the pens had not been labeled with the date opened. Additionally, the cart had 1 Lantus Solostar pen opened, available for use, and labeled with an open date of 4/10/16 and an expiration date of 5/8/16. Review of the manufacturer's instructions showed Lantus SoloStar pens expired 28 days after opening or removing from the refrigerator and Humalog KwikPens expired 28 days after opening or removing from the refrigerator. Interview with RN #3 at that time confirmed the insulin pens needed to be labeled with the dates they were opened. 2. Interview with the DON on 5/26/16 at 10:30 AM confirmed the expectation is for the nurses to label insulin pens for resident use with the open and expiration dates. 3. Review of the facility staff meeting minutes dated 5/10/16 and 5/19/16 and titled "State Preparedness" showed "Review of state survey and readiness...Be sure to date insulin pens for 28 days except for Levimir pens (42 days)."	F 431		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441	The facility will establish and maintain an infection control program designed to provide a safe, sanitary,	07-10-2016

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F 441 SS=D	Continued From page 30 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	and comfortable environment and to help prevent the development and transmission of disease and infection. A) The facility will ensure it effectively implements measures to prevent the development and transmission of infection for residents #55, #59, and all other residents. B) The facility will implement a quality monitoring tool to ensure that catheter drainage bags are not placed on the floor. C) Monitoring of compliance will be done by a weekly random review of two residents who have catheter drainage bags by the infection control nurse using the quality improvement monitoring tool until substantial compliance has been met. D) The facility will implement a policy in regards to disposable respiratory equipment and maintenance. E) Monitoring of compliance will be done by weekly random review of two residents who have respiratory equipment. F) Education will be provided to all nursing staff on the importance of effectively implementing measures to prevent the development and transmission of infection. G) Nursing staff not effectively implementing measures to prevent the development and transmission of infection will receive immediate in-servicing and corrective action will be taken. H) Results will be reported quarterly as part of the facility Quality Assurance Program.	

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F 441	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure infection control practices were implemented during 2 random observations. The practice affected 1 sample resident (#59) and 1 non-sample resident (#55). The findings were: 1. Observation on 5/23/16 at 5:10 PM showed resident #55 was in bed and his/her catheter drainage bag was filled with urine and positioned on the floor. The following concerns were identified: a. Interview with the infection control nurse on 5/26/16 at 8:30 AM revealed the drainage bag should not be stored on the floor as it would increase the resident's risk of infection. b. Review of the policy titled "Urinary Catheter Care" revised 4/27/16 showed "... Purpose The purpose of this procedure is to prevent infection of the resident's urinary tract...General Guidelines...11. Be sure the catheter tubing and drainage bag are kept off the floor..." 2. Observation on 5/24/16 at 9:30 AM showed CNA #3 took resident #59's vital signs and identified the resident's oxygen saturation was low. The CNA obtained the resident's oxygen cannula, dropped it on the floor, then applied it to the resident's nares. Interview with the infection control nurse on 5/26/16 at 8:30 AM revealed if oxygen tubing is on the floor it should be changed before it is applied to the resident because it would increase the risk of infection.	F 441		
F 502 SS=D	483.75(j)(1) ADMINISTRATION	F 502	The facility will ensure it provides laboratory services to meet the needs of its residents and is providing quality and timeliness of the services.	07-10-2016

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

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F 502	Continued From page 32 The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure ordered laboratory tests were performed for 2 of 10 sample residents (#11, #39) who had orders for laboratory tests. The findings were: 1. Review of telephone orders for resident #11 showed an order dated 5/19/16 for the resident to have complete blood count (CBC), comprehensive metabolic panel (CMP), urinalysis, and thyroid-stimulating hormone (TSH) tests performed. Review of the resident's medical record failed to show any results for a TSH test. Interview with the DON on 5/26/16 at 8:31 AM revealed the laboratory test was missed, and was not completed. 2. Review of telephone orders for resident #39 showed an order dated 5/18/16 for the resident to have CBC, CMP, and hemoglobin A1c (HgA1c) tests performed. Review of the resident's medical record failed to show any results for an HgA1c test. Interview with the DON on 5/26/16 at 8:31 AM revealed the laboratory test was missed, and was not completed.	F 502	The facility will ensure it provides laboratory services to meet the needs of its residents and are providing quality and timeliness of the services. A) The facility will ensure ordered laboratory tests are performed for residents #11, #39, and all other residents. B) Nursing staff will be educated on the importance of ensuring labs are drawn and completed correctly in a timely manner. C) Monitoring of compliance will be done weekly by random review of two lab request forms by a supervisor using the quality improvement monitoring tool until substantial compliance has been met. D) Nurses not verifying accurate lab request forms will receive immediate in-servicing and corrective action will be taken. E) Results will be reported quarterly as part of the facility Quality Improvement Program.	07-10-16