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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

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F 000	INITIAL COMMENTS A complaint survey was conducted in conjunction with the recertification survey by the Office of Healthcare Licensing and Surveys on 7/11/16 through 7/14/16. The complaint survey was prompted by complaint intakes WY00002255 and WY00002258. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living BIMS- Brief Interview for Mental Status CAA- Care Area Assessment CNA- Certified Nurse Aide DON- Director of Nursing Services LPN- Licensed Practical Nurse MAR- Medication Administration Record MDS- Minimum Data Set RN- Registered Nurse TAR- Treatment Administration Record Less commonly used abbreviations will be annotated in each deficiency.	F 000	F157 Notify of Changes Corrective Action-Facility has consulted with physician regarding change of condition for resident #40 and new orders were obtained. Resident #40 was offered dental services and declined. Identification of Others-All residents with a change of condition have a potential to be affected by this practice. An audit of clinical documentation for the past two weeks will be completed by nursing management to identify change of condition and physician notification. Corrective actions will be taken as needed for identified concerns.	8/26/16
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	F 157	Systemic Changes-The facility will immediately inform the resident, consult with resident's physician; and if known, notify the resident's legal representative or interested family member when there is a significant change in the resident's physical, mental or psychosocial status or a need to alter treatment significantly. The Director of Nursing or designee will review clinical reports daily Monday through Friday during daily clinical meeting to determine any	

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

ADMINISTRATOR 8/5/16

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

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

Spoke with John Buckholtz 8/22/2016

POC accepted with agreed changes
Jean Yunni 8/22/2016
DOC 8/26/2016

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F 157	Continued From page 1 significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of 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 and resident interview, the facility failed to ensure a change in condition was reported to the physician for 1 of 6 sample residents (#40) with a change in condition. The findings were: 1. Observation on 7/12/16 at 12:55 PM showed resident #40 was positioned at the South nursing station. The resident asked the nurse, "Can I have a pain pill for my jaw?" 2. Observation on 7/12/16 5:30 PM showed the resident was seated at the dining room table attempting to eat. After taking a bite of food, the resident began to cry and stated" my teeth hurt so bad, help I got bad teeth...it hurts, help...I can't	F 157	resident change of condition and physician notification. Corrective actions will be taken as needed. The Staff Development Coordinator or designee will provide education to licensed nursing staff regarding immediately informing the resident, consult with resident's physician; and if known, notify the resident's legal representative or interested family member when there is a significant change in the resident's physical, mental or psychosocial status or a need to alter treatment significantly. Monitoring-The Director of Nursing or designee will audit compliance through weekly random record review of documentation of 10 residents on each nursing unit with change of condition for physician notification of change of condition for 90 days. Results of the physician notification audits will be reported to the QAPI committee monthly by the Director of Nursing for tracking and trending. The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for 3 months and then reassess the need for	

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F 157	Continued From page 2 hardly eat anything." 3. Interview with the resident on 7/12/16 at 3:23 PM revealed s/he had a "tooth ache." 4. Interview with RN #3 on 7/12/16 at 3:15 PM revealed pain medication had been administered to the resident earlier in the day because the resident had complaints of "jaw and neck pain." 5. Review of the medical record on 7/12/16 and 7/13/16 failed to show any evidence the physician had been notified of the resident's jaw and/or tooth pain. 6. Interview with physician #1 on 7/14/16 at 12:55 PM verified he was unaware the resident had been experiencing jaw and/or tooth pain.	F 157	continued monitoring based on compliance.	
F 165 SS=E	483.10(f)(1) RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL A resident has a right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished. This REQUIREMENT is not met as evidenced by: Based on resident interview, review of resident council meeting minutes, staff interview, and review of facility policies and procedures, the facility failed to ensure residents on 2 of 2 units (South, North) were free to voice concerns without fear of discrimination or reprisal. The findings were:	F 165	F165 Right to Voice Grievances without Reprisal Corrective Action-Specific residents were not cited nor specific concerns identified. Identification of Others-All residents have the potential to be affected by this practice. The NHA and designees will interview facility residents or their designee to identify any grievances. Any identified concerns will be addressed and follow up will be completed with resident by NHA or designee to determine resolution and satisfaction. Systemic Changes-The facility will provide all residents the right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished.	8/26/16

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F 165	Continued From page 3 1. Resident interviews during the survey from 7/11/16 through 7/14/16 revealed 9 of 16 residents interviewed expressed fear or concerns they would be treated poorly or retaliated against in some way for bringing up concerns related to care or conditions in the facility. The following concern were identified: a. Four of these residents revealed they no longer brought up concerns to the facility because the facility did not listen to him/her before when issues were brought up. The residents further revealed fears of being "ignored" or having care withheld by the facility if they reported concerns to the facility. b. One resident expressed fear the facility would "take away pain medication" if s/he brought up concerns related to care provided in the facility. c. Three residents expressed fear the facility would "throw me out" if they reported a problem to the facility. d. One resident revealed s/he had brought up concerns to the facility in the past, and that nothing was done. S/he further stated "you learn to bite your tongue," and was fearful of "being labeled a troublemaker" if s/he were to reveal additional concerns to the facility. 2. Review of the resident council minutes from March 2016 revealed "Residents state that at times when they want to talk to a manager or ask them a questions [sic], they do no [sic] get a response back in a timely manner." Review of the resident council minutes from April - June 2016 showed no concerns were listed related to administration, nursing, dietary, social services, care plan process, activities, housekeeping/laundry, or maintenance. During a group interview with 10 residents on 7/5/16 at 1	F 165	The NHA or designee will educate staff regarding resident right's, concern identification, concern communication and action and concern follow-up. Monitoring-The NHA or designee will audit compliance through weekly concern form review of concern documentation and follow up for 90 days. Results of audits will be reported to the QAPI committee by the NHA or designee monthly for 3 months for tracking and trending. The QAPI Committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for 3 months and then reassess the need for continued monitoring based on compliance.	

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F 165	Continued From page 4 PM, the residents revealed they no longer brought up concerns to the facility because they felt the facility did not work toward resolving the concerns. 3. Interview with the social services director on 7/14/16 at 7:20 PM revealed he was unaware of resident's fears of voicing concerns. He further stated "that's a problem." 4. Review of the policy and procedure titled "Truly Listening to Our Customers (TLC) Program," last revised June 2013, showed: "Any resident, his or her representative, family member, employee, or appointed advocate may file a concern without fear of threat or reprisal in any form..."	F 165	F203 Notice Requirements Before Transfer / Discharge Corrective Action-Resident #96 no longer resides in the facility. Identification of Others-Facility records of discharges in past 3 months have been reviewed and there are no other residents who were issued a discharge notice. Systemic Changes-The facility will notify the resident and, if known, a family member or legal representative	8/26/16
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of	F 203	of the resident of the transfer/discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record and appropriate notice information. The NHA or designee will educate discharge planning personnel relating to notice requirements before transfer/discharge. Monitoring-The NHA or designee will audit compliance through weekly review of notice of transfer/discharge documentation. Results of the discharge audits will be reported to the QAPI committee by NHA or designee for tracking and	

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F 203	Continued From page 5 individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to ensure the discharge notice included all required elements for 1 of 1 facility initiated discharges reviewed (#96). The findings were: Review of the 6/17/16 discharge notice showed	F 203	trending for 3 months. The QAPI Committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance as needed monthly for 3 months and then reassess the need for continued monitoring based on compliance.	

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F 203	Continued From page 6 resident #96 had behaviors which created a threat to staff and other residents. The discharge noticed failed to show the discharge location. The discharge notice showed "[Resident] will be discharged from this facility once a safe discharge location is secured." Interview with the DON on 7/14/16 at 2:35 PM verified the resident was transferred to the hospital on 6/17/16 due to violent behaviors toward staff and other residents. She further confirmed the notice of discharge did not show the location to where the resident was to be discharged. Interview with the social service designee (SSD) on 7/14/16 at 3:10 PM verified the resident was transferred to the hospital and was not accepted back to the facility. The SSD stated he assisted the hospital case worker with placement for the resident; however, the process took several weeks and the resident was placed in an appropriate facility the week of July 11, 2016.	F 203	F241 Dignity and Respect for Individuality Corrective Action-Resident #81 will be evaluated by Occupational Therapy or designee for upper extremity range of motion impairment and self feeding, including positioning at table. Based on evaluation and recommendations care plan will be updated and nursing staff who work with this resident will be educated on interventions by SDC or designee. Identification of Others-The Therapy Director or designee will observe residents during meals for proper positioning to facilitate independence and self feeding. Further follow up will be done for any identified concerns. Systemic Changes-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. The Staff Development Coordinator or designee will educate nursing staff in promoting care for residents in a manner and in an environment that maintains or enhances each resident's	8/26/16
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff and resident interview, the facility failed to promote dignity for 1 of 16 sample residents (#81). The findings were: Review of the 5/2/16 quarterly MDS assessment for resident #81 showed s/he had upper extremity	F 241		

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F 241	Continued From page 7 range of motion impairment on one side, and required supervision and setup help only with eating. Review of the ADL Functional/Rehabilitation Potential CAA from the 1/31/16 admission MDS assessment showed the resident had limited range of motion on the left side subsequent to a stroke. The following concerns were identified: a. Observation of the midday meal on 7/11/16 beginning at 11:40 AM showed the resident was seated in a wheelchair in the dining room with his/her legs elevated. The resident's wheelchair was perpendicular to the table on the left side, requiring the resident to stretch his/her right arm across his/her body to reach the plate of food on the table. Continued observation showed the resident was barely able to reach the food on the plate with the tip of the fork, and was unable to reach any of his/her glasses of fluids. b. Review of the resident's care plan for ADL self-performance, last revised on 6/24/16, and Nutritional Risk, last revised on 6/24/16, showed no evidence the resident required any special positioning for meals. c. Interview with the rehabilitation program manager on 7/14/16 at 4:40 PM confirmed the resident required proper positioning to effectively feed him/herself, and this need should be care-planned and the staff trained to carry out the intervention.	F 241	dignity and respect in full recognition of his or her individuality. Monitoring-The Therapy Director or designee will audit for dignity concerns with positioning / self feeding in the dining room through random weekly observation rounds for 90 days. Results of the dignity audits will be reported to the QAPI committee by the Therapy Director or designee for tracking and trending monthly for 3 months. The QAPI Committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for 3 months and then reassess the need for continued monitoring based on compliance.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be	F 246	F246 Reasonable Accommodation of Needs Corrective Actions-Resident #45 will be evaluated by Occupational Therapy for safety with use of motorized wheelchair and interventions to increase independent wheelchair mobility. Based on outcomes of therapy evaluation her care plan will be updated with recommendations.	8/26/16

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F 246	Continued From page 8 endangered. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, resident interview, and staff interview, the facility failed to ensure accommodation of needs for 1 of 1 sample resident (#45) who had a special wheelchair. The findings were: Medical record review showed resident #45 had diagnoses which included osteoarthritis, heart failure, and chronic obstructive pulmonary disease. Review of the 5/27/16 annual MDS assessment showed the resident was cognitively intact with a BIMS score of 15, could not walk and required the assistance of one staff member for locomotion with use of a wheelchair. The following concerns were identified: a. Observation on 7/13/16 at 11:20 AM showed the resident was in the main dining area in a non-motorized wheelchair. Interview with the resident at that time revealed s/he had a motorized wheelchair that had been removed by staff, and the resident was now dependant on staff for locomotion to get around the facility. b. Review of the 6/13/16 "SBAR [situation, background, assessment, recommendations] Communication Form and Progress Note" showed the resident ran over another resident's foot with the motorized wheelchair, and review of a 4/10/16 incident showed a similar incident happed with the wheelchair. The review showed the resident had his/her electric wheelchair removed and replaced with a manual wheelchair on 6/14/16 after a therapy evaluation. Medical record review showed no offer to re-educate the	F 246	Identification of Needs-Residents requiring accommodations of needs/preferences have the potential to be affected by this practice. Residents will be screened by Therapy Director or designee to identify residents with potential for increased independence in wheelchair mobility. Follow up will done for those identified. Systemic Changes-The facility will provide services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. The Staff Development Coordinator or designee will educate nursing staff regarding provision of services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Monitoring-The Director of Nursing or designee will audit compliance through weekly random observation rounds of 10 residents for accommodation of	

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F 246	Continued From page 9 resident on safe use of the motorized wheelchair, and there was no documentation in the record that staff addressed how the resident felt about this life change. c. Interview with the resident on 7/13/16 at 4:35 PM confirmed there were no interventions put in place that may have allowed continued use of the motorized wheelchair after the 6/13/16 incident. The resident further stated that s/he missed the independence from use of his/her electric wheelchair, and would do whatever it took to have that independence back. d. Interview on 7/13/16 at 4:50 PM with the rehabilitation program manager confirmed the resident should have been offered the opportunity to re-educate on use of the motorized wheelchair. e. Interview on 7/14/16 at 7:45 AM with the social service designee confirmed the facility should have considered re-training for the resident on use of the motorized wheelchair, and should have taken into account the impact on the resident from the loss of independence in moving around the facility.	F 246	needs in all resident care areas for the next 90 days. Results of the accommodation of needs audits will be reported to the QAPI committee by the Director of Nursing or designee for tracking and trending monthly for 3 months. The QAPI Committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for 3 months and then reassess the need for continued monitoring based on compliance.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 5 of 5 hallways (North hallway, South hallway, short hallways 1, 2, and 3) were clean and in good repair. The findings were:	F 253	F253 Housekeeping and Maintenance Services Corrective Actions-All identified areas have been cleaned, repaired or replaced as applicable. Identification of Others-All resident care areas are subject to this practice. Systemic Changes-Administration will educate maintenance and housekeeping staff on preventative maintenance and routine repair and cleaning scheduling.	8/26/16

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F 253	Continued From page 10 1. Observation of the resident area on 7/11/16 from 11:22 AM through 2:58 PM identified the following concerns: a. The floor in front of the emergency doors in the assisted dining room had a darkened area of dirt at the base. Observation showed this area remained dirty on 7/14/16 at 8:40 AM. b. The carpet on the south hallway had multiple darkened stains, which remained during the survey. This area covered the hallway extending from residents rooms #1 through #23. c. All hallways without carpet had an orange-brown accumulation between the floor and the baseboards. Observation on 7/14/16 at 8:20 AM showed the accumulation remained. 2. Tour of the facility on 7/12/16 from 7:45 AM through 9:10 AM identified the following concerns: a. The bathroom floor of room #105 had a crack in the flooring 27 inches in length that was darkened with dirt and created an uncleanable surface. b. The bathroom floor of room #106 was sticky when walked on and had darkened yellowish stains. The middle of the bedroom floor had a 6 inch crack and a 3 inch crack in the tile that were darkened with dirt and created an uncleanable surface. c. The bed by the door of room #107 had a fall mat by the bed that was dirty with blackened stains. The toilet in the bathroom had rust-colored stains around the base of the toilet. d. The right inner doorframe on the bathroom door of room #104 had a chipped area from the floor to 12 inches up that exposed the metal underneath and created an uncleanable surface. e. The bathroom floor of room #103 had	F 253	Monitoring-The facility will audit compliance through weekly observation rounds in all resident care areas. Results of audits will be reported to the QAA committee for tracking and trending. For 3 months. JK 8/22/16	

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F 253	Continued From page 11 stains on the floor in front of the sink. Multiple cracks were noted in the tile of the bedroom; with the longest of which was 18 inches. This created uncleanable surface. f. The bathroom floor of room #108 was dirty with blackened stains at various spots on the floor. There was a 6-inch crack in the tile of the bedroom floor that was darkened with dirt and created an uncleanable surface. g. The tile floor of room #102 had 3 star-shaped cracks in the floor with the longest being 14 inches in length. These cracks were darkened with dirt and created an uncleanable surface. The bathroom floor was dirty with darkened stains all around the toilet. h. The bedroom floor and the bathroom floor in room #109 had multiple darkened stains. The i. Nine light fixtures in the hallway from rooms #100 to #110 had noticeable debris including dead insects in the fixtures. j. The bathroom floor of room #101 had multiple darkened stains. k. The front doorframe of room #110 was chipped from the floor to 6 inches up and created an uncleanable surface. The floor of the bedroom had several brownish stains. The bathroom floor had multiple darkened and pinkish stains that were sticky when walked on. l. The hallway in front of the South nurses' station was dirty with small pieces of debris. m. The floor of room #111 had a 8-inch cracked tile in the front middle area that was darkened with dirt. The bathroom floor had multiple darkened stains. n. The bedroom and bathroom floors in room #123 had multiple darkened stains. o. The bedroom floor in room #122 had multiple darkened stains. p. The bathroom floor in room #112 had	F 253		

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F 253	Continued From page 12 darkened stains in front of the toilet. q. The bedroom floor in room #134 had multiple dirty areas with small pieces of debris. The bathroom floor had a rust-colored ring around the toilet base. r. The bedroom floor in room #132 had multiple blackened stains. s. The left wall in the bathroom of room #131 had a 4-inch scrape that created an uncleanable surface. The floor in the bedroom by the first bed had 4 (12 inch by 12 inch) tiles that were noticeably stained. t. The bathroom floor in room #135 had a 16-inch long crack that was darkened with dirt and created an uncleanable surface. u. The bathroom floor in room #136 had a 4-inch long crack that was darkened with dirt, which created an uncleanable surface. The floor had multiple darkened stains. v. The bedroom floor in room #138 had multiple darkened stains. w. The hallway floor outside of room #138 had two cracks in the tile that were darkened with dirt and created an uncleanable surface. The longest crack measured 12 inches. x. The floor by the window in room #139 had multiple darkened stains. y. The floor by the window in room #140 had multiple darkened stains on the floor. z. The floor in front of the North nurses' station had multiple darkened stains. aa. The floor in the bedroom of room #141 had a 36-inch long crack that was darkened with dirt and created an uncleanable surface. bb. The two firedoors in the hallway outside of room #141 had dirt and trash collected behind each door. cc. The floor in room #142 had multiple darkened stains.	F 253		

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F 253	Continued From page 13 dd. The front floor area at the doorway of room #152 had black tape that was collecting dirt. ee. The bedroom floor of room #143 had multiple darkened stains. ff. The bathroom floor in room #144 had darkened stains in front of the toilet. gg. The back wall and floor of the bathroom in room #146 had 12 inches of silver tape that was pulling loose and collecting dirt. hh. The hallway outside of room #148 had a 72-inch crack that was darkened with dirt. ii. The floor divider between the North shower room and the hallway was damaged which created an uncleanable surface. 3. An observation on 7/13/16 at 11:15 AM in room #148 showed wall behind the head of the first bed had a 14-inch by 2-inch gouge in the wall that exposed the sheet rock material, that appeared to be crumbling. In addition, there were multiple small chips in the wall next to the bed. These damaged areas resulted in surfaces that were uncleanable. 4. Tour of the facility on 7/14/16 from 8:20 AM through 8:40 AM identified the following concerns: a. The floor in room #120 had a cracked 12 by 12 inch tile by the first bed that was darkened with dirt and debris and had an uncleanable surface. b. The toilet in the bathroom of room #119 had a rust-colored ring around the base. The bedroom floor had 4 (12 inch by 12 inch) tiles with multiple cracks that were darkened with dirt and created an uncleanable surface. c. The toilet in room #118 was raised off of the floor on the left this exposed a small gap between the floor and the toilet. This created an	F 253		

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F 253	Continued From page 14 uncleanable surface. In addition, there was a rust-colored ring at the base of the toilet. d. The toilet base in the bathroom of room #117 had a rust colored ring at the caulk line. e. The floor in room #125 had 1 (12 inch by 12 inch) cracked tile in the middle of the room that was darkened with dirt and created an uncleanable surface. f. The front floor area of room #126 had a 24-inch crack across the tiles that was darkened with dirt and created an uncleanable surface. g. The floor of room #127 had a 6-inch crack that crossed 2 tiles that was darkened with dirt and created an uncleanable surface. h. The floor of room #128 had 3 (12 inch by 12 inch) tiles that were cracked and darkened with dirt which created an uncleanable surface. i. The floor of room #148 had multiple darkened stains on the floor. j. The floor of room #151 had a tile with a chipped area that measured 2 inches by 1 inch and created an uncleanable surface. k. The kick plate on the outside of the front door to room #118 was pulled loose from the door to 14 inches on the left and had a jagged edge. Interview with the maintenance director on 7/14/16 at 9:30 AM revealed he was unaware of the kick plate damage and would attend to it to prevent injury. 5. The following housekeeping issues in the dining areas were identified: a. Observation on 7/11/16 at 11:26 AM showed the assisted dining room floor had not been cleaned after breakfast. Residents were seated for the noon meal service and there was scattered food debris under the tables and around the edges of the room. b. Observation on 7/11/16 at 4:13 PM showed	F 253		

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F 253	Continued From page 15 the main dining area and the television area adjacent to this dining room had not been swept or mopped since the noon meal. The floors had food debris scattered under the tables and around the edges of the walls. The tables in both areas had not been wiped down. At 5 PM the tables were covered with table cloths; however, they were not cleaned prior to applying the covers. The floors remained unclean for the evening meal. 6. The following interviews were obtained related to the facility environment: a. During a group interview on 7/12/16 at 1 PM with 10 residents in attendance, the residents revealed the facility was not clean, especially the hallways and floors. They added that was "not acceptable" to them in their home. b. Confidential resident interview on 7/12/16 at 10:20 AM revealed the facility was not clean, particularly the baseboards in the hallways. The resident added "it's clean this week" with the survey in process. The resident also stated, "I have to beg them to clean the toilet." 7. Interview with the housekeeping supervisor on 7/14/16 at 8:50 AM verified she was aware of the housekeeping issues. She stated the facility planned to remodel the floors which would include replacing the carpets, and she believed this would make it easier to clean the floors. However, she was unaware of a timeframe for the floor remodeling. 8. Interview with the maintenance supervisor on 7/14/16 at 9:30 AM verified he was aware of the floor issues and the facility planned to repair and replace the flooring. However, the facility failed to establish a specific plan with a timeframe to	F 253		

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F 253	Continued From page 16 address those issues.	F 253	F272 Comprehensive Assessments	
F 272 SS=D	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	Corrective Actions-Resident #40 comprehensive assessment was completed on 08/12/16. Identification of Others-Residents requiring comprehensive assessments are at risk for being affected. Systemic Changes-DDCM/Designee will educate IDT (Social Services, Activities, Dietary, MDS Staff) on the completion of CAA's and analysis of findings on or before 8/12/16. Monitoring-DDCM/Designee will review ~~up to~~ 3 comprehensive assessments weekly for four weeks then monthly for three months for CAA completion with analysis of findings. Results of audits will be reported to the QAA committee for tracking and trending. Results of CAA audits will be reported to the QAPI committee by the Resident Care Management Director or designee for tracking and trending monthly for 3 months. The QAPI Committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for 3 months and then reassess the	8/26/16 JY 8/22/16

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F 272	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the comprehensive assessment of resident needs in a variety of areas for 1 of 17 sample residents (#40). The findings were: 1. Review of the 4/30/16 admission MDS assessment for resident #40 showed the following areas triggered for further assessment: ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Dehydration/Fluid Maintenance, and Pressure Ulcer. The following concerns were identified: a. Review of the CAA for ADL Functional/Rehabilitation Potential showed only "resident currently working with PT [physical therapy] and OT [occupational therapy]." There was no analysis of the resident's ADL needs or goals. b. Review of the CAA for Falls showed only "resident has not had a fall since admission." There was no analysis of the resident's condition or needs in this area. c. Review of the CAA for Urinary Incontinence and Indwelling Catheter showed only "resident currently working with PT and OT, and understand the importance of using call light for assistance." There was no analysis of the resident's condition or needs in this area. d. Review of the CAA for Pressure Ulcer showed only "resident admitted with ulcer." There was no analysis of the resident's condition or	F 272	need for continued monitoring based on compliance.	

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F 272	Continued From page 18 needs in this area. e. Review of the CAA for Dehydration showed only "resident admitted with dx [diagnosis] of UTI [urinary tract infection], fluid encouragement happening." There was no analysis of the resident's condition or needs in this area. 2. Interview with the MDS coordinator on 7/14/16 at 2:18 PM confirmed some of the CAAs were not fully developed. She further revealed she was new to the position of MDS coordinator, and could use more training on MDS processes.	F 272	F278 Assessment Accuracy / Coordination / Certified Corrective Action-Resident #96 no longer resides in the facility. Resident #62 has had the MDS modified to reflect accurate resident status. Resident #86 has had the MDS modified to reflect accurate resident status.	8/26/16
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each	F 278	Identification of Others-A review of assessments completed within the last 30 days will be conducted to ensure pain, falls (section J) and behaviors (section E) has been coded correctly. Systemic Changes-The facility will ensure assessments accurately reflect the resident's status. DDCM/Designee ~~with education~~ will educate MDS Director, MDS Coordinator and Social Services on coding/assessing sections J (falls, pain) and section E (behaviors) accurately and per RAI guidelines. Monitoring-DDCM/Designee ~~with~~ will review 2 -3 MDS's per week for accurate coding of sections J and E for four weeks then monthly for three months. Results of audits will be reported to the QAA committee for tracking and trending.	8/22/16 SK

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F 278	Continued From page 19 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the accuracy of the MDS assessments for 3 of 17 sample residents (#62, #86, #96). The findings were: 1. Review of the medical record of resident #62 revealed two interdisciplinary post fall reviews dated 4/14/16 and 6/3/16. Review of the quarterly MDS assessment dated 6/9/16 revealed the resident had not had any falls since the last assessment dated 3/20/16. Interview with the MDS coordinator on 7/14/16 at 2:15 PM revealed she did not know why the falls were missed. 2. Review of the 2/5/16 history and physical showed resident #86 had myalgias (muscle pain) and pain in the lower back due to compression fracture. Review of the 2/11/16 admission MDS assessment showed s/he was understood and could understand others, and had a BIMS score of 15 out of 15, indicating the resident was cognitively intact. The following concerns were identified: a. Further review of the 2/11/16 admission MDS assessment showed the answer to question J0200 "Should Pain Assessment Interview be Conducted?" was coded as "No." b. Review of the 5/9/16 quarterly MDS assessment showed the answer to question J0200 was again coded as "No." c. Interview with the MDS coordinator and RN	F 278	Results of the MDS coding audit will be reported to the QAPI committee by the Resident Care Management Director or designee for tracking and trending monthly for 3 months. The QAPI Committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for 3 months and then reassess the need for continued monitoring based on compliance.	

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F 278	Continued From page 20 #1 on 7/14/16 beginning at 2:18 PM confirmed a pain interview should have been conducted with the resident, and the coding was in error. 3. Review of the 6/5/16 quarterly MDS assessment showed resident #96 had no behaviors other than wandering which occurred 1 to 3 days during that time frame. However, review of the care plan for behavior problems initiated on 3/16/16 showed the resident had physical aggression with hitting and yelling. This care plan was also updated on 6/20/16 to reflect an incident of physical aggression toward a nurse that occurred on 6/4/16. Interview on 7/14/16 at 2:35 PM with the MDS coordinator and RN #1 verified physically aggressive behaviors had been documented during the look back period. They then acknowledged the behaviors should have been recorded on the quarterly MDS assessment and this was an inaccuracy.	F 278	F309 Provide Care / Services For Highest Well Being Corrective Action-Resident #40 is receiving and the facility is providing 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. Facility has consulted with physician regarding change of condition for resident #40 and new orders were obtained. Resident #40 was offered dental services and declined.	8/26/16
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 observation, medical record review, and resident, staff and physician interview, the facility failed to effectively manage pain for 1 of 14 sample residents (#40) with pain. The findings	F 309	A pain evaluation has been completed for resident #40 and plan of care reviewed and updated to include non-pharmacological interventions for pain. Identification of Others-All residents with a change of condition has the potential to be affected by this practice. An audit of clinical documentation for the past two weeks will be completed by nursing management to identify change of condition and physician notification. Corrective actions will be taken as needed for identified concerns.	

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F 309	Continued From page 21 were: Observation on 7/12/16 at 12:55 PM showed resident #40 was in his/her wheelchair at the South nursing station. The resident said, "Can I have a pain pill for my jaw?" RN #3 replied that she had given the resident a pain pill "three hours ago." No alternative treatment for pain was offered. The following concerns were identified: a. Review of physician orders showed the resident had an order for hydrocodone-acetaminophen 5 mg/325 mg (generic name for Norco, an opioid pain medication), one table to be administered every 6 hours as needed for pain. b. Review of the controlled drug record for the resident's hydrocodone-acetaminophen 5 mg/325 mg showed a dose was administered to the resident on 7/12/16 at 8:30 AM. c. Interview with RN #3 on 7/12/16 at 3:15 PM confirmed the resident was "complaining of pain earlier today ...[s/he] said it was the jaw and neck ...I gave [him/her] a Norco ...it seemed to help, then [s/he] asked for more later and I had to tell [him/her] it was too soon, it had only been three hours." d. Interview with the resident on 7/12/16 at 3:23 PM confirmed the resident was experiencing pain that day. The resident stated, "I had a Norco earlier, and I can have another later." e. Review of the medical record on 7/12/16 at 4:04 PM failed to show the resident had been assessed for pain, or provided with additional pain medication. f. Observation on 7/12/16 at 5:30 PM showed the resident was seated at a table in the assisted dining room. The resident began to eat, and then started to cry. As the resident cried, s/he stated, "My teeth hurt so bad...it hurts, help...I can't	F 309	The Director of Nursing or designee will identify residents with significant pain and review pain evaluation and care plan for non-pharmacological interventions for pain. Revisions will be made as needed based on outcome of audit. Systemic Changes-Facility will 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. The Director of Nursing or designee will review clinical reports daily Monday through Friday during daily clinical meeting to identify any resident with new or unresolved pain and to determine any resident change of condition and physician notification. Corrective actions will be taken as needed. The Staff Development Coordinator or designee will provide education to licensed nursing staff regarding immediately informing the resident, consult with resident's physician; and if known, notify the resident's legal representative or interested family member when there is a significant	

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F 309	Continued From page 22 hardly eat anything." At the request of the surveyor, RN #3 came to the dining room, told the resident she had a pain pill for him/her, and took the resident away from the dining room to assess the pain. g. Interview with physician #1 on 7/14/16 at 12:55 PM verified he was unaware the resident had been experiencing jaw pain, and he did not recall receiving any report of the resident's jaw pain. h. Medical record review on 7/14/16 at 3:11 PM showed a new physician's order for doxycycline hyclate (an antibiotic) 100 mg to be administered by mouth two times a day for dental infection.	F 309	change in the resident's physical, mental or psychosocial status or a need to alter treatment significantly. The Staff Development Coordinator or designee will educate all nursing staff on evaluation and delivery of 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. The education will include pain management and non-pharmacological	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility failed to ensure required assistance for bathing was provided for 9 of 14 sample residents (#7, #12, #22, #39, #41, #43, #48, #61, #62) who required assistance with ADLs. The findings were: 1. Review of the 6/27/16 care plan for ADL performance showed resident #22 required extensive assistance by 1 staff member with	F 312	interventions for pain. Monitoring-The Director of Nursing or designee will conduct 10 random resident observations / pain interviews per nursing unit weekly for 90 days for effective pain management. The Director of Nursing or designee will audit compliance through weekly random record review of documentation of 10 residents on each nursing unit with change of condition for physician notification of change of condition for 90 days. Results of the pain management audits and physician notification audits will be reported to the QAPI committee monthly by the Director of Nursing or designee for tracking and trending. The	

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F 312	Continued From page 23 showering twice weekly and as necessary. The care plan also showed a "sponge bath" was to be provided when a full bath or shower could not be tolerated. The following concerns were identified: a. Observation on 7/11/16 at 11:23 AM showed the resident appeared to be poorly groomed. The resident had whiskers and caked dark matter underneath the fingernails of both hands. On 7/11/16 at 3:50 PM CNA #9 was in the resident's room cleaning the resident's nails. The aide was also attempting to get the electric razor to work for shaving the resident's face. b. Interview with the resident on 7/12/16 at 7:55 AM revealed s/he was "happy" to have received a shave, it had been several days. c. Review of the bathing documentation for June 2016 showed the resident received showers on: 6/2, 6/8, 6/15, 6/17, and 6/29. d. The July 2016 documentation from 7/1 to 7/14 showed the resident received a shower on 7/4/16. There were also refusals shown on 6/16, 6/23, 6/27, 7/3, and 7/13. e. The care plan failed to address frequent refusals or approaches to use related to refusals of bathing. 2. Review of the June and July 2016 shower records showed resident #39 had gaps of a week or more between baths. These included: 6/14/16 to 6/21/16 (7 days), and 6/21/16 to 6/28/16 (7 days), 6/28/16 to 7/10/16 (12 days). Review of the care plan showed the resident was dependent on staff to provide showers. Interview with resident #39 on 7/14/16 at 9:30 AM confirmed the resident had a ten day period where no showers were offered or occurred. The resident had requested assistance with showering and was told by CNA staff that no shower aide was available due to vacation coverage.	F 312	QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for 3 months and then reassess the need for continued monitoring based on compliance. F312 ADL Care Provided For Dependent Residents Residents #7, #12, #22, #39, #41, #43, #48, #61 and #62 are receiving the necessary services to maintain good nutrition, grooming and personal oral hygiene. Resident #22 has received a shower, nail care and a shave. Resident #39 has received a shower. Resident #7 has received a shower. The care plan will be updated to reflect interventions for refusals of bathing. Resident #61 has received a shower. Resident #41 has received a shower. Resident #12 has received a shower. Resident # 62 has received a shower. Resident #48 has received a shower. Resident #43 has received a shower. Identification of Others-An audit of bathing records for the past week will	8/26/16

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F 312	Continued From page 24 3. Medical record review showed resident #7 had diagnoses which included arthritis and non-Alzheimer's dementia. Review of the resident's care plan initiated on 6/20/16 showed the resident required extensive assistance by 1 staff member with showering "twice a week and as necessary." Review of the resident's shower documentation for June and July 2016 showed the resident did not receive showers twice per week. The documentation showed the resident was showered on 6/1, 6/13, 6/29, 7/3, and 7/6. Further review showed the resident refused a shower on 6/9, 6/20, and 6/27. The documentation showed the resident did not receive a shower from 6/14/16 until 6/29/16 (15 days) with refusals on 6/20/16 and 6/27/16. In addition, the facility failed to document the reason for refusal, or what intervention the facility would attempt in order to accommodate the resident with acceptable alternative shower times. 4. Review of the 6/3/16 quarterly MDS assessment showed resident #61 did not receive a shower during the 7 day look-back period. Review of the ADL care plan, revised 6/27/16, revealed the resident required extensive assistance by 1 staff with showering "twice weekly and as necessary." Review of the facility shower documentation for June 2016 showed the resident received showers on 6/7, 6/9, 6/18, and 6/24. Review of the 7/1/16 through 7/14/16 shower documentation showed the resident received a shower on 7/7. 5. Review of the 6/14/16 admission MDS assessment showed resident #41 required physical help of one staff member for bathing. Review of the ADL care plan related to	F 312	be reviewed and any resident who has not received a bath in accordance with care plan will be identified. Bathing will provided for those identified and care plan reviewed and updated if needed. Nail care and shaving will also be completed if needed. Systemic Changes-All residents who are unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene. The Staff Development Coordinator or designee will educate nursing staff on how to provide services to residents who are unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming and personal and oral hygiene. The education will include bathing, nail care, shaves, documentation of bathing and refusals. Monitoring-The Director of Nursing or designee will audit compliance through weekly random observations of 10 residents per nursing unit of resident appearance including nail care and shaving for 90 days. The Director of Nursing or designee will audit bathing documentation two	

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F 312	Continued From page 25 showering, revised 7/12/16, revealed the resident required extensive assistance by 1 staff with showering "twice a week and as necessary." Review of the facility shower documentation from 7/1/16 through 7/14/16, showed the resident received a shower on 7/6. 6. Review of the 2/27/16 care plan for ADL performance showed resident #12 was totally dependant on staff to provide bathing. The care plan showed staff were to provide a "shower or bed bath twice weekly and as necessary." Review of the bathing documentation for June and July 2016 revealed the resident did not always receive 2 baths per week. The documentation showed the resident received 5 baths during June (6/2, 6/13, 6/18, 6/21, 6/26) and 3 baths (7/1, 7/10, 7/14) between 7/1/16 to 7/14/16. 7. Review of the 6/9/16 quarterly MDS assessment showed resident #62 did not receive a shower during the 7 day look-back period. Review of the facility shower documentation for June 2016 revealed the resident received showers on 6/10, 6/13, 6/17, and 6/26. Review of the shower documentation for July 7/1/16 through 7/14/16 showed the resident received showers on 7/1 and 7/10. 8. Review of the care plan revised on 7/11/16 showed resident #48 required extensive assistance of one staff person for bathing twice per week and as necessary. Review of the electronic bathing records and the paper documentation presented by LPN #1 for June 2016 and July 1 - 14, 2016 revealed the resident received a bath on 6/13, 6/16, 6/18, 6/29, 6/30, and 7/10. Refusal to bathe occurred on 6/1, 6/14, and 6/15.	F 312	times per week for completion of bath or documentation of refusal and other interventions tried. Results of the grooming observation audit and bathing documentation audit will be reported to the QAPI committee monthly for 3 months by the Director of Nursing or designee for tracking and trending. The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for 3 months and then reassess the need for continued monitoring based on compliance.	

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F 312	Continued From page 26 9. Review of the shower records for resident #43 showed the resident received a shower on 6/7/16, 6/14/16, 6/19/16, 6/28/16 and 7/11/16. Review of the care plan showed the resident was dependent on staff to provide showers. Review of this documentation showed no refusals. 10. Confidential resident interview during the survey from 7/11/16 through 7/14/16 revealed the facility was not providing showers consistently. The resident stated s/he had waited 1 1/2 to 2 weeks between showers in the past, and had to give him/herself bed baths in between showers. The resident further stated his/her bathing schedule was "supposed to be two times a week." 11. Confidential resident interview during the survey from 7/11/16 through 7/14/16 revealed the resident went up to 2 weeks between showers, and had learned to wash him/herself with wipes between showers. 12. Interview with LPN #1 on 7/14/16 at 4:16 PM verified the residents should get showers/baths twice per week. She also verified the system used to document bathing was not reliable and it was very difficult to put together the information to see if the resident's were receiving their baths. She stated there were times when she could not provide information to families who had questioned the showers/baths given to their loved ones.	F 312		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329	F329 Drug Regimen Free of Unnecessary Drugs Residents #41, #59, #61 and #72 have drug regimen free from unnecessary medications. Resident #72's behavior monitoring has been reviewed and updated as needed to include specific target behaviors, non-pharmacological interventions, and effectiveness and side effects. Resident #61's behavior monitoring has been reviewed and updated as needed to include specific target behaviors, non-pharmacological interventions, and effectiveness and side effects. Resident #41's behavior monitoring has been reviewed and updated as needed to include specific target behaviors, non-pharmacological interventions, and effectiveness and side effects. Resident #59's behavior monitoring has been reviewed and updated as needed to include specific target behaviors, non-pharmacological interventions, and effectiveness and side effects. Identification of Others-All residents receiving medications have the potential to be affected by this practice.	8/26/16

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F 329	Continued From page 27 unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure effective monitoring of medications used to treat behavior symptoms for 4 of 12 sample residents (#41, #59, #61, #72) who used these medications. The findings were: 1. Review of the 7/6/16 quarterly MDS assessment showed resident #72 had diagnoses that included Alzheimer's disease, dementia, encephalopathy, and anxiety. Review of the resident's active physician orders showed the	F 329	The Social Service Director or designee will audit behavior monitoring records for specific target behaviors, non-pharmacological interventions and effectiveness and side effects, Corrective actions will be taken as needed for those identified. Systemic Changes-Facility will ensure all residents receiving medication will have a drug regimen free from unnecessary drugs. The Staff Development Coordinator or designee will educate licensed nursing staff regarding drug regimen free from unnecessary medications, monitoring and documentation. .Monitoring-The Director of Nursing or designee will complete random audit of 10 resident behavior monitoring records per nursing unit for compliance weekly for 3 months.. Results of audits will be reported to the QAA committee for tracking and trending. Results of the behavior monitoring documentation audit will be reported to the QAPI committee monthly for 3 months by the Director of Nursing or designee for tracking and trending. The QAPI committee will evaluate the effectiveness of the plan based on	

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F 329	Continued From page 28 resident was prescribed Seroquel (antipyschotic medication) twice daily and lorazepam (antianxiety medication) every 6 hours as needed (PRN) for anxiety. Further review of the active orders showed the facility was to observe each shift for behaviors related to use of these medications, as well as side effects. Review of the July treatment administration record (TAR) from 7/1/16 through 7/14/16 revealed the following concerns: a. Review of the monitoring related to antianxiety medication use showed 3 behaviors were being monitored, with no indication of what the behaviors were. Further review showed the resident demonstrated behaviors during 6 shifts (7/1, 7/3, 7/10, 7/11, 7/12, and 7/14), as documented with a 'y' on the record. Additionally, the TAR showed non-pharmacological interventions were attempted 1 time, as indicated with a 'y'. Also, an intervention was determined to be effective, as indicated with a 'e'. Side effects were monitored on 17 of 26 shifts during that time period, all marked with a 'n' indicating no side effects noted. i. Review of the nurse progress notes for those dates the resident was marked as having behaviors showed no corresponding notes to indicate what behaviors were present during those shifts, what interventions (pharmacological or non pharmacological) were attempted, or the effectiveness of the interventions. ii. Review of the July 2016 MAR showed the resident was given PRN lorazepam 3 days (7/1, 7/3, and 7/5). b. Review of the monitoring related to antipsychotic medication use showed 3 behaviors were being monitored, with no indication of what the behaviors were. Further review showed the resident demonstrated behaviors during 3 shifts,	F 329	trends identified and implement additional interventions as needed to ensure compliance monthly for 3 months and then reassess the need for continued monitoring based on compliance.	

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F 329	Continued From page 29 as indicated with a 'y' on the record. Additionally, the TAR showed non-pharmacological interventions were attempted 1 time, as documented with a 'y'. Further, an intervention was determined to be ineffective, as indicated with a 'I' on the TAR. Side effects were monitored on 17 of 26 shifts during that time period. i. Review of the nurse progress notes for the dates the resident was marked as having behaviors showed no corresponding notes to indicate what behaviors were present during the shift, what interventions (pharmacological or non-pharmacological) were attempted, or the effectiveness of the interventions. 2. Review of the 6/3/16 quarterly MDS assessment showed resident #61 had diagnoses that included schizophrenia, anxiety, and depression. Review of the resident's active physician orders showed the resident was prescribed Seroquel (antipsychotic medication) daily, Klonopin (sedative medication used to treat anxiety) twice daily, and Mirtazapine (antidepressant medication) daily. Further review showed the facility was to observe each shift for behaviors and side effects related to the use of these medications, and was to document 'y' if the resident was having behaviors or side effects, and 'n' if the resident was not having behaviors or side effects. Review of the July 2016 TAR revealed the following concerns: a. Review of the monitoring related to use of antidepressants showed the resident was marked as displaying behaviors during 2 shifts (7/10, 7/12). Further review showed non-pharmacological interventions were attempted both times, with the outcome marked as 'e' for effective. Side effects were documented as being monitored only on 16 of 26 shifts.	F 329		

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F 329	Continued From page 30 i. Review of the July nurse progress notes for the dates the resident was indicated as having behaviors showed no corresponding notes to indicate what behaviors were present or what non-pharmacological interventions were attempted. b. Review of the monitoring related to use of antianxiety medications showed the resident did not display behaviors during any shifts. Side effects were documented as being monitored on 16 of 26 shifts. c. Review of the monitoring related to use of antipsychotic medication showed the resident displayed behaviors during 3 shifts (7/2, 7/3, 7/6). There was no indication of interventions attempted or effectiveness. Side effects were documented as being monitored on 16 of 26 shifts. i. Review of the July nurse progress notes for the dates the resident was indicated as having behaviors showed no corresponding notes to indicate what behaviors were present, what interventions (pharmacological or non-pharmacological)were attempted, or the effectiveness of interventions. 3. Review of the 6/14/16 admission MDS assessment showed resident #41 had diagnoses that included anxiety and manic depression. Review of the resident's active physician orders showed the resident was prescribed quetiapine (antipsychotic medication) daily and venlafaxine (antidepressant medication) daily. Further review showed the facility was to observe each shift for behaviors and side effects related to the use of these medications, and was to document 'y' if the resident was having side effects and 'n' if the resident was not having side effects. Review of the July 2016 TAR from 7/8/16 through 7/13/16	F 329		

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F 329	Continued From page 31 revealed the following concerns: a. Review of the monitoring related to antidepressant use showed the facility was documenting with the use of a check mark each shift to indicate monitoring was completed. There was no documentation to indicate if the resident was displaying behaviors or side effects. i. Review of the July nurse progress notes showed no documented evidence the behaviors or side effects were being monitored. b. Review of the monitoring related to antipsychotic use showed the facility was documenting with the use of a check mark each shift to indicate monitoring was completed. There was no documentation to indicate if the resident was displaying behaviors or side effects. i. Review of the July nurse progress notes showed no documented evidence the behaviors or side effects were being monitored. 4. Review of the 5/11/16 quarterly MDS assessment for resident #59 showed diagnoses that included schizophrenia and manic depression. Review of the active physician orders showed the resident was prescribed Seroquel (antipsychotic medication) as needed, Haldol Decanoate (injectable antipsychotic medication) every 28 days, and Lamictal (mood stabilizing medication) daily. Further review showed the facility was to observe for behaviors and side effects related to the use of these medications each shift. Review of the July TAR from 7/8/16 through 7/12/16 revealed the following concerns: a. Review of the monitoring related to antipsychotic use showed the facility was documenting with the use of a check mark each shift to indicate monitoring was completed. There was no documentation to indicate if the resident was displaying behaviors or side effects.	F 329		

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F 329	Continued From page 32 i. Review of the nurse progress notes for the time period showed no documented evidence behaviors or side effects were being monitored. b. Review of the monitoring for sedative/hypnotic medication use showed it was unclear in the instructions. The instructions showed "Document: 'Y' if resident is free of behaviors or side effects. 'N' if the resident is not having behaviors or side effects." The order was not clear how the facility would document if the resident was displaying behaviors or side effects. Continued review showed the facility was documenting with the use of a check mark each shift to indicate monitoring was completed. There was no documentation to indicate if the resident was displaying behaviors or side effects. i. Review of the nurse progress notes for the time period showed no documented evidence behaviors or side effects were being monitored. 5. Interview with the district director of clinical services and DON on 7/14/16 at 3 PM verified the monitoring system was confusing and stated "we know we have some opportunities for improvement in this area."	F 329	F332 Free of Medication Error Rate of 5% or More Corrective Action-Resident #41 is now receiving prescribed medications timely in accordance with physician's orders. The physician was notified of medications being given upon return from pass on 7/14/16. Identification of Others-All residents receiving medication have the potential to be affected by timing of medication administration if they are out on pass from facility. Systemic Changes-Facility will ensure residents receiving medication are free of medication error rates of 5% or more. The Staff Development Coordinator or designee will educate licensed nursing staff to ensure residents are free of medication rates of 5% or more. The education will include management of medication if resident will be out of facility when medications are due to be administered. Monitoring-The Director of Nursing or designee will audit compliance of medication administration through random weekly random observation audit of medication administration for	8/26/16
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, policy and procedure review, and staff interview the facility failed to ensure medications were	F 332		

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F 332	Continued From page 33 administered as ordered for 2 of 31 medication administration observations, resulting in an error rate of 6.45%. The findings were: a. Observation of the medication pass on 7/14/16 beginning at 12:30 PM showed RN #2 prepared 1 tablet of gabapentin 600 mg, and a Combivent/Respimat 20-100 mcg [microgram] inhalant for resident #41. When attempting to administer the medications, the nurse was unable to locate the resident and eventually discovered the resident had left the facility for a physician appointment. Interview with the nurse at that time revealed there had been some confusion about her shift that day, she had not received report the resident would be leaving the facility, and had not known she would need to administer the resident's medications before the resident left. The medications were not administered at that time. b. Review of the July 2016 physician orders recapitulation for resident #41 showed orders initiated 6/1/16 for gabapentin 600 mg to be administered three times daily, and ipratropium bromide/albuterol aerosol solution 20-100 mcg (generic for Combivent/Respimat) to be administered four times daily. c. Review of the resident's July 2016 MAR showed the gabapentin was to be administered at 8 AM, 12 PM, 4 PM, and 8 PM, and Combivent/Respimat was to be administered at 8 AM, 12 PM, 5 PM, and 9 PM. d. Review of the facility's policy and procedure for medication administration showed "...6. Administer medications within 60 minutes of the scheduled time..." e. Interview with RN #2 on 7/14/16 at 5:50 PM revealed the resident returned to the facility at approximately 2 PM and received his/her medications at that time.	F 332	6 residents per nursing unit. Results of audits will be reported to the QAA committee for tracking and trending. Results of the medication administration audit will be reported to the QAPI committee monthly for 3 months by the Director of Nursing or designee for tracking and trending. The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for 3 months and then reassess the need for continued monitoring based on compliance.	

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F 356 SS=E	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of daily staff postings, the facility failed to ensure the nurse staff posting met all required elements. In addition, the facility failed to ensure the	F 356	F356 Posted Nurse Staffing Information Corrective Action-Facility is posting Nurse Staffing information. Identification of Others-Only one posting of nursing staffing is required. Systemic Changes-Facility will ensure on a daily basis the following information is posted: facility name, current date, total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift-Registered Nurses, Licensed practical/vocational nurses, certified nurse aides and resident census. Facility will ensure the information is retained for 18 months. The Staff Development Coordinator or designee will educate the nursing management team and nursing scheduler on content, frequency and retention of posting. Monitoring-The Director of Nursing or designee will audit compliance through weekly reviews of posted nurse staffing information and retention of posted information. Results of audits will be reported to the QAA committee for tracking and trending.	8/26/16

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F 356	Continued From page 35 required 18 months of postings were maintained. The findings were: 1. Observation of staff posting during the survey dates of 7/11/16 through 7/14/16 showed the following elements were missing: a. Review of the staff postings showed the facility failed to include registered nurses, licensed practical nurses, and certified nurse aides. The two categories listed were, "Licensed Nursing Staff" and "Unlicensed Nursing Staff." b. The review showed the postings listed staff under the two categories documented. However, the postings failed to include actual hours worked. 2. Upon request for the last 18 months of staff postings, the facility provided the postings for only 12 dates: 6/21/16, 6/22/16, 6/24/16, 6/27/16, 6/28/16, 6/30/16, 7/6/16, 7/7/16, 7/11/16, 7/12/16, 7/13/16 and 7/14/16. 3. Interview with the district director of clinical services on 7/12/16 at 5:10 PM confirmed the facility failed to include the required categories of registered nurses, licensed practical nurses, and certified nurse aides in the daily staff postings. She also confirmed the facility failed to include actual hours worked, and the facility failed to keep 18 months of staff postings.	F 356	Results of the staffing posting audit will be reported to the QAPI committee monthly for 3 months by the Director of Nursing or designee for tracking and trending. The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for 3 months and then reassess the need for continued monitoring based on compliance.	
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.	F 368	F368 Frequency of Meals / Snacks at Bedtime Corrective Action-Residents on the north and south unit are now being offered bedtime snacks daily. Identification of Others-All facility residents have the potential to be affected by not offering bedtime snacks. Systemic Changes-The Staff Development Coordinator will educate nursing staff regarding offering and documenting a snack at bedtime daily.	8/26/16

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F 368	Continued From page 36 There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, the facility failed to ensure bed time snacks were offered on 2 of 2 units (North and South). The findings were: Interview with a group of 10 residents on 7/12/16 at 1 PM revealed snacks at bedtime were not being offered. Some of the residents were aware that snacks were available at the nursing desk and they could have them if they asked for them. However, staff did not offer the snacks to all residents at bedtime. Interview with CNA #7 on 7/12/16 at 5:21 PM stated snacks were available after dinner for the residents on the South unit. The snacks were put out at the nursing desk and residents could help themselves. She said the snacks available included half sandwiches and crackers. Interview with CNA #5 on 7/12/16 at 5:01 PM revealed evening snacks were available at the North unit nurses' station and residents could access them if they wanted. She further added	F 368	The Dietary Manager will educate dietary staff on providing adequate number of bedtime snacks daily. Monitoring-The Director of Nursing or designee facility will audit compliance with bedtime snacks through weekly audit of resident interviews and documentation. Results of audits will be reported to the QAA committee for tracking and trending. Results of the bedtime snack audit will be reported to the QAPI committee monthly for 3 months by the Director of Nursing or designee for tracking and trending. The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for 3 months and then reassess the need for continued monitoring based on compliance.	

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F 368	Continued From page 37 there were several residents she knew who liked snacks at night, so she would take snacks to them.	F 368	F371 Food Procure, Store / Prepare/ Serve	8/20/16
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: Based on observation and staff interview the facility failed to ensure that food was stored, prepared and distributed under sanitary conditions in 1 of 1 kitchens. The findings were: Observation on 7/11/16 at 10:13 AM and 7/13/16 at 11:13 AM showed the following sanitary issues: a. The exteriors, including the handles of the refrigeration and freezer storage units, were soiled with grime and sticky food residues. These included 3 units near the back door and the refrigerator unit and juice and beverage cooler on the south wall. b. The interior and exterior of the 2 convection ovens and the microwave were soiled with food build-up which needed to be cleaned. c. The bases of the two blenders on the south prep table were noted to be soiled with dried food in the crevices and around the operation	F 371	Corrective Action-All areas identified have been cleaned and/or repaired. The handles of refrigeration and freezer units have been cleaned. The interior and exterior of convection ovens and microwaves have been cleaned. The blenders have been cleaned. The cutting board on the south prep area has been replaced. The hood walls, vents and lights above the range / griddle has been cleaned. The walls by the south prep table and serving window have been cleaned. The wall by the dish room entry has been cleaned. The walls of the dish room and ceiling have been repaired. The kitchen ceiling by the central hood has been repaired. The floor by the ice machine has been cleaned. The kitchen floors have been cleaned. The ceiling piping in the main kitchen, storage room and dish room have been cleaned. The label on the iced tea dispenser has been removed and ice tea dispenser has been cleaned. The handles on the food transport cart have been replaced. Identification of Others-All residents have the potential to be affected by this practice.	

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F 371	Continued From page 38 switches. The blenders were not in use at this time. d. The white cutting board on the south prep table was visibly scored and discolored. e. The hood walls, vents and lights above the range/griddle were heavily soiled with thick grease. Droplets of grease were visible on the outside walls of the hood. f. The wall behind the south prep table and the service window between the kitchen and the dining room were splattered with dried food which needed to be cleaned. g. The wall to the right of the dish room entryway was splattered with dried food from the floor extending upward 6.5 feet which needed to be cleaned. h. The four walls of the dish room and the ceiling showed chipped and peeling paint which created uncleanable surfaces. i. A large area on the kitchen ceiling (unable to be measure due to the height) near the central hood revealed the paint and/or ceiling material was peeling away. j. The floor at the base of the ice machine showed a significant amount of white dried substance which had been spilled or leaked. The ice machine was located next to the chemical supply cabinet. k. The kitchen floors were heavily soiled around the edges near the walls and the stationary equipment. l. The ceiling piping in the main kitchen, dry storage room, and dish room showed noticeable build-up of grease and dust. m. The dispenser of iced tea had a label on the front of the plastic. This label was worn and peeling away. The dispenser was washed regularly, however, was not fully cleanable due to the label.	F 371	An in-depth kitchen sanitation audit will be complete by the Registered Dietician or designee to identify kitchen sanitation concerns and corrective actions will be taken as needed. Systemic Changes-Facility will ensure food is procured, stored, prepared and served in sanitary conditions. The Dietary Manager will educate food service staff to ensure food is procured, stored, prepared and served in sanitary conditions. Training will include cleaning schedules and cleaning methods. Monitoring-The Dietary Manager will audit compliance with kitchen sanitation through weekly observation and audit of sanitary conditions. Results of audits will be reported to the QAA committee for tracking and trending. The Registered Dietician or designee will conduct a kitchen sanitation audit weekly for 3 months. Results of the audit will be reported to the Dietary Manager and NHA. Results of the kitchen sanitation audits will be reported to the QAPI committee monthly for 3 months by	

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F 371	Continued From page 39 n. Observation of the food transport cart used to deliver resident meals was noted to have two broken handles which were held together with duct tape. This created an uncleanable surface. 2. Interview with the dietary manager on 7/13/16 at 11:35 AM verified the kitchen was in need of additional cleaning, and the contracted dietary department staff were responsible for cleaning the kitchen. The manager also stated the maintenance issues such as the peeling paint had been communicated to the facility's staff. 3. According to Food code 2013, Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."	F 371	the Dietary Manager or designee for tracking and trending. The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for 3 months and then reassess the need for continued monitoring based on compliance.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		

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F 441	Continued From page 40 (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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, the facility failed to ensure infection prevention practices were implemented during random observations involving residents (#3, #22, #27, #28, #40, #43, #45, #52). The findings were: 1. Review of the facility's policy and procedure on "Glucometer Decontamination" showed "...Policy: The glucometer will be decontaminated with the facility approved wipes following use on each resident..." The following concerns were identified: a. Observation on 7/13/16 at 4:33 PM	F 441	F441 Infection Control, Prevent Spread Corrective Actions-RN #3 has received 1:1 education on glucometer cleaning between residents (resident #40, #99). RN #4 has received 1:1 education on glucometer cleaning glucometer after use before storing (resident #45). The wheelchair cushion for resident #27 has been replaced. Proper hand hygiene while assisting residents #3, #28, #52, #22, and #43 is now being practiced to prevent spread of infection. Identification of Others-All residents have the potential to be affected by this practice. Systemic Changes-The Staff Development Coordinator or designee will educate Licensed Nursing staff on proper decontamination procedures for glucometers. The Staff Development Coordinator or designee will educate nursing staff regarding proper hand sanitation between residents and tasks in the dining room. The Staff Development Coordinator will educate nursing staff on replacing	8/26/16

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F 441	Continued From page 41 showed RN #3 used the facility glucometer to obtain a fingerstick blood glucose measurement on resident #40. After obtaining the result, the nurse returned to the medication cart and placed the glucometer on the top of the cart. She did not clean or disinfect the glucometer in any way. At 4:45 PM, the nurse prepared to use the glucometer again to obtain a fingerstick blood glucose measurement on resident #99. At that time, the nurse was stopped from performing the test by the surveyor. Interview with the RN at that time revealed she had worked at the facility for a year, and had never been instructed on the need to disinfect glucometers between uses. b. Observation 7/13/16 at 5:37 PM showed RN #4 used the facility glucometer to obtain a fingerstick blood glucose measurement on resident #45. After obtaining the result the nurse placed the glucometer into the pocket of her scrub top. At 5:44 PM the nurse placed the glucometer into the top drawer of the medication cart without cleaning or disinfecting the glucometer in any way. 2. Observation on 7/11/16 at 11:42 AM showed CNA #5 as she assisted non-sample resident #3 with his/her meal of meatloaf, mashed potatoes and gravy, corn, roll, cookie, and pudding. The CNA stood next to the resident to assist with eating and then moved a chair from another table, sat down, and continued to assist with the meal. The aide did not perform hand hygiene. At 11:47 AM the CNA moved to another table to assist an unidentified resident to eat. The aide did not perform hand hygiene between assisting the two residents. During the timeframe of 11:56 AM and 12:18 PM the aide alternated between residents, handled a roll and cookie with her bare hands, and refilled juice glasses allowing her	F 441	wheelchair cushions or cushion covers as needed. Monitoring-The Staff Development Coordinator or designee will audit compliance through 2 random weekly observation audit per nursing unit of glucometer cleaning between resident use and storage for 3 months. Results of audits will be reported to the QAA committee for tracking and trending. The Staff Development Coordinator or designee will audit compliance through random observations of 10 residents per nursing unit for cleanliness of wheelchair cushions weekly for 3 months. Results of audits will be reported to the QAA committee for tracking and trending. The Staff Development Coordinator or designee will audit compliance through random observation audits of hand hygiene in each dining room 4 times per week on different meals on a variety of days. Results of audits will be reported to the QAA committee for tracking and trending. Results of the infection control audits will be reported to the QAPI committee monthly for 3 months by the Staff Development Coordinator or designee for tracking and trending. The	

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F 441	Continued From page 42 finger to touch the inside surface of the glass. In addition, the aide moved a wheelchair and adjusted her clothing. The aide did not perform hand hygiene during this timeframe. 3. Observation on 7/14/16 at 4 PM showed resident #27 was seated in a motorized wheelchair. Beneath the resident was a thick foam cushion that had no cover over it. The resident smelled strongly of urine and this smell lingered in the area surrounding the resident. Interview with RN #3 at that time revealed the resident refused to transfer from his/her wheelchair more than once a day, and as a result, was not toileted. The resident instead voided large amounts of urine onto the cushion. RN #3 confirmed this practice impacted the other residents in the facility, particularly during meals and activities. Interview on 7/14/16 at 8:50 AM with the housekeeping supervisor revealed she believed staff took the wheelchair cushion for resident #27 out and "hosed it off" weekly. Review of the July "South Wheelchair Cleaning Schedule" and the "Wheelchair Cleaning Log" showed wheelchairs were cleaned on a weekly rotating schedule. The logs did not indicate if wheelchair cushions were cleaned at that time. 4. Observation of the lunch meal service on 7/11/16 from 11:23 AM through 11:57 AM in the North dining room showed CNA #10 assisted residents with dining, which included assistance to residents #28, #52, #22, and #43. During the observation, CNA #10 picked up various items of food with her bare hands and alternated between the four residents without performing hand hygiene. At 11:50 AM, the aide pushed the wheelchair of resident #28, then continued to assist residents #52, #22, and #43 without	F 441	QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for 3 months and then reassess the need for continued monitoring based on compliance.	

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F 441	Continued From page 43 performing hand hygiene. 5. Interview with the infection control practitioner on 7/14/16 at 10:50 AM confirmed glucometers should be sanitized between uses as per manufacturer's instructions, and hand hygiene should always be performed between residents and tasks. She further confirmed the facility failed to conduct random monitoring of handwashing. 6. According to the 2012 facility policy titled, "Hand Hygiene", the purpose of hand hygiene is "To decrease the risk of transmission of infection by appropriate hygiene." Review of "Waterless Handwashing Products" showed the following, "If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all clinical situations other than those listed under "Handwashing" above."	F 441		
F 498 SS=E	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on review of employee education files and staff interview, the facility failed to ensure evidence the competency skills and techniques were demonstrated for 4 of 4 CNAs reviewed (#1, #2, #3, #4). The findings were: 1. Review of the education file for CNA #1	F 498	F498 Nurse Aide Demonstrate Competency / Care Needs Corrective Actions-Competency skill checks will be completed for CNA #1by the Staff Development Coordinator. Competency skills checks will be completed for CNA #2 by the Staff Development Coordinator. Competency skills checks will be completed for CNA #3 by the Staff Development Coordinator. Competency skills checks will be completed for CNA #4 by the Staff Development Coordinator. Identification of Others-All residents have the potential to be affected by this practice. Systemic Changes-Facility will ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs. The Staff Development Coordinator or designee will complete competency skill checks with current CNA's before date of compliance. Competency skills checks will be completed with CNA's during orientation period and then annually by Staff Development Coordinator or designee.	8/26/16

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

(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 498	Continued From page 44 showed she started work on 6/24/16. There was no evidence in the file to show the facility determined the CNA was competent in skills and techniques to care for the residents. 2. Review of the education file for CNA #2 showed she started work on 6/24/16. There was no evidence in the file to show the facility determined the CNA was competent in skills and techniques to care for the residents. 3. Review of the education file for CNA #3 showed she started work on 5/5/16. There was no evidence in the file to show the facility determined the CNA was competent in skills and techniques to care for the residents. 4. Review of the education file for CNA #4 showed she started work on 3/24/16. There was no evidence in the file to show the facility determined the CNA was competent in skills and techniques to care for the residents. 5. Interview with the district director of clinical services on 7/14/16 at 8:20 PM revealed they would look for these competencies. As of 7/28/16 there was no information provided.	F 498	Monitoring-The Director of Nursing or designee will audit compliance with CNA skills competencies through monthly review of competency evaluation completion for newly hired CNA's and annual competency CNA during month of hire. Results of audits will be reported to the QAA committee for tracking and trending. Results of the CNA competency audits will be reported to the QAPI committee monthly for 3 months by the Director of Nursing or designee for tracking and trending. The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for 3 months and then reassess the need for continued monitoring based on compliance.	
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient	F 514	F514 Records – Complete / Accurate / Accessible Corrective Action-Residents #7, #12, #22, #39, #41, #48, #61 and #62 have medical records that are complete, accurate and accessible. Bathing	8/26/16

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F 514	Continued From page 45 information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on review of resident ADL records, and staff interview, the facility failed to ensure the records were accurate, readily accessible, and systematically organized for 9 of 14 sample residents (#7, #12, #22, #39, #41, #48, #61, #62) whose ADL records were reviewed. The findings were: Interview with district director of clinical services on 7/13/16 at 4:30 PM revealed the facility would allow access to the electronic ADL documentation if the surveyors requested the resident information needed and the facility would print it. Later the facility allowed the surveyors to view the electronic information with a staff member. Review of the electronic resident ADL records revealed the information was not complete and/or accurate. Interview with LPN #1 on 7/14/16 at 10:49 AM while providing access to the information, verified the electronic records were not accurate, and it appeared information was missing. She revealed there were also paper records kept related to showers/bathing. The LPN thought the missing information was related to a lack of understanding by the CNAs of how to use the program and/or the importance of documenting the bathing in the electronic charting. The following concerns were identified: a. Review of the ADL documentation records for June and July 2016 showed sample residents	F 514	documentation has been completed for residents #7, #12, #22, #39, #41, #48, #61 and #62 for ~~most~~ most recent bath or refusal. We are unable to correct previous bathing documentation. Identification of Others-All residents have the potential to be affected by this practice. An audit of bathing record documentation for the past week will be completed and follow up completed for missing documentation. If the bath was refused this will be documented. Systemic Changes-Facility will ensure clinical records on each resident in are maintained in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The Staff Development Coordinator will educate nursing staff regarding accurate documentation of bathing and refusals of baths. Monitoring-The Director of Nursing or designee will audit compliance through weekly audit of bathing documentation.. Results of audits will be reported to the QAA committee for tracking and trending	JY 8/22/16

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F 514	Continued From page 46 #7, #12, #22, #39, #41, #43, #48, #61, #62 had lapses of 7 days or greater between baths/showers. b. The paper documentation was not systematically organized in a way to provide information to the surveyors in a timely manner. The paper documents were requested on 7/14/16 during the electronic review at 10:49 AM and were provided more than 5 hours later at 4:16 PM. c. Interview with LPN #1 on 7/14/16 at 4:16 PM verified the system used to document bathing was not reliable and it was very difficult to put together the information. She stated there were times when she could not provide information to families that had questions about schedules and showers/baths given to their loved ones due to the nature of the record keeping.	F 514	Results of the bathing documentation audit will be reported to the QAPI committee monthly for 3 months by the Director of Nursing or designee for tracking and trending. The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for 3 months and then reassess the need for continued monitoring based on compliance.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee	F 520	F520 QAA Committee – Members / Meet Quarterly / Plans Corrective Action-The facility maintains a proper quality assessment and assurance committee meeting at least quarterly. F157, F241, F253, F312, F371, F441, F498, and F520 compliance has been added to the QAPI committee agenda for periodic review. Identification of Others-All facility residents have the potential to be affected by deficient practice.	8/26/16

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F 520	Continued From page 47 except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview, and review of compliance history information, the facility failed to ensure an effective quality assessment and assurance (QAA) program was being implemented to prevent repeat deficient practice (F157, F241, F253, F312, F371, F441, F498, F520) from previous surveys. The findings were: 1. Review of the Casper 3 report last updated on 7/4/16 showed on the 6/18/15 survey, the facility was cited for dignity issues (F241), maintenance and housekeeping issues (F253), providing assistance for residents with ADL limitations (F312), food/kitchen sanitation issues (F371), infection control issues (F441) and quality assessment and assurance program issues (F520). The facility had corrected the identified deficient practice from the survey. However, the facility is cited with non-compliance of these repeated issues on the 7/14/16 survey. 2. Review of the statement of deficiencies for the 9/11/15 complaint survey showed deficiencies cited included: notification of changes (F157), dignity issues (F241), housekeeping and maintenance (F253), food/kitchen sanitization issues (F371) and nurse aide education issues (F498). The facility had corrected the identified	F 520	Systemic Changes-The NHA or designee will educate interdisciplinary team on function, composition and duties of the quality assessment and assurance committee. Monitoring-The NHA or designee will audit compliance through review content and frequency of committee meetings. Results of audits will be reported to the QAA committee for tracking and trending. The QAPI committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for 3 months and then reassess the need for continued monitoring based on compliance.	

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F 520	Continued From page 48 deficient practice from the survey. However, the facility is cited with non-compliance of these repeated issues on the 7/14/16 survey. 3. Interview with the DON and the regional administrator on 7/14/16 at 5:20 PM revealed the QAA program continued to collect data in a variety of areas; however, repeated problems continued.	F 520		