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

PRINTED: 07/26/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536056	A. BUILDING _____ B. WING _____	C 07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE VIEW CARE CENTER	1325 SAGE STREET ROCK SPRINGS, WY 82901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted by Healthcare Licensing and Surveys on 7/11/16 through 7/14/16. The complaint survey was prompted by complaint intakes WY00002242 and WY00002264. The following common abbreviations are used throughout this document: CNA- Certified Nurse Aide DON- Director of Nursing IDT- Interdisciplinary Team LPN- Licensed Practical Nurse MDS- Minimum Data Set mg- milligrams Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in	F 157		

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

[signature] RN, BSN 8/23/16

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 25 2016
Healthcare Licensing and Surveys

POC accepted 8/25/2016 Jean Yonn
2 spoke with Kristy Boisvert
DOC 8/10/2016

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F 157	Continued From page 1 §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 observation, medical record review and staff interview, the facility failed to ensure the physician was notified of signs and symptoms of a change in health status for 1 of 11 sample residents (#13) reviewed for changes in condition. The findings were: Review of the medical record showed resident #13 was admitted to the facility from a hospital on 7/5/16. Further review revealed the resident had bloody urine in his/her urinary catheter drainage bag at the hospital and this continued after admission to the facility. Review of the daily nurses notes showed staff noted the bloody urine and had concerns about the resident "pulling" the catheter. Periodic observations from 7/11/16 through 7/14/16 revealed the urine in the resident's drainage bag was bloody with visible clots. Interview with RN #1 on 7/14/16 at 9:30 AM revealed the resident had bloody urine for 9 days and staff had not reported this to the physician.	F 157	**F 157 483.10(b)(11) Notify of changes (injury/decline/room, ETC)** **Corrective Action** The physician was immediately notified of hematuria for resident #13, new orders received to discontinue urinary catheter. Upon removal of urinary catheter no further hematuria has developed. **ID Of Others** A 100% audit of all residents documentation in charts has been conducted by DON/Designee to ensure all changes of health status has been identified and reported to physician. **Systemic Changes** The IDT will review charts daily to monitor for any significant changes in any resident conditions and physician notification has occurred.. LN staff will receive education on Physician notification with any resident's significant change in health status. **Monitoring** The DON/Designee will audit the 24 hours book weekly x 4 weeks and monthly x 3 months to ensure proper notification of all significant changes.The Results will be brought to QAPI monthly for determination of need/frequency of on-going monitoring. Furthermore education regarding facility policy of notification for health status changes will be provided for all new hire licensed nursing staff during orientation. Compliance Date: 8/10/16	

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F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure staff followed the written plan of care for 1 of 10 sample residents (#19). The findings were: Review of the care plan for resident #19 showed an update dated 5/2/16 which instructed staff to keep the resident in a common area when up in the wheelchair (w/c); otherwise the resident was to be in bed when in his/her room. In addition, on 6/2/16 the care plan was updated to include instructions to change the call light button to a pressure pad call light. Observation on 7/12/16 at 9:50 AM revealed CNA #1 and CNA #2 assisted the resident to the bathroom. Afterwards, the CNAs left the resident in the w/c in his/her room. In addition, observation at that time revealed the call light was a button type, and not a pressure pad. During an interview on 7/13/16 at 4:36 PM the DON stated staff should not have left the resident in the w/c in his/her room; she stated the resident was to be in bed or the recliner when left in the room. In addition, she stated the resident should have a pressure pad call light.	F 282	**F 282 483.20(k)(3)(ii) Services By Qualified Persons/Per Care Plan** **Corrective Action** A pressure pad call light has been placed in the room of resident #19. Resident #19's plan of care regarding placement for safety has been reviewed with staff and implemented accordingly. **ID Of Others** A 100% facility audit was conducted by DON/Designee of all residents care plans to ensure identified interventions are accurate and are being carried out accordingly. **Systemic Changes** DON/Designee will conduct in-service with LN staff to emphasize importance of following established care plans. DON/Designee will conduct random weekly audits x 4 weeks and monthly x 3 to ensure care plans are followed with services provided. **Monitoring** Results of audits conducted will be brought to QAPI monthly for determination of need/frequency of on-going monitoring. All new hire licensed nursing staff will receive education during orientation on the importance of following all written plans of care for residents. Compliance Date: 8/10/16	
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309	**F 309 483.25 Provide Care/Services For Highest Well Being** **Addressing #1. And #2.** **Corrective Action** Resident #28 was given pain medication. The licensed nurse for	

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F 309	Continued From page 3 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, staff interview, and medical record and policy and procedure review, the facility failed to ensure effective pain management was provided for 2 of 7 sample residents (#26, #29) and 1 non-sample resident (#28) who required pain management. The findings were: 1. Review of the pain management policy and procedure, revised June 2016, showed when a prn (as needed) pain medication is administered the licensed nurse should document on the reverse side of the medication administration record or in an appropriate location in the electronic medical record, the medication given, the reason, and the pain evaluation scale. After the prn medication has had time to take effect, the licensed nurse documents results/effectiveness. 2. Review of the medical record for resident #28 revealed the physician ordered Tramadol 50 mg 4 times daily prn for chronic pain on 6/8/16. Further review showed this order replaced the previous order for 3 times daily. Observation on 7/13/16 at 10:20 AM revealed the resident complained about his/her hands hurting while sitting in the wheelchair at the nurses' desk. At that time occupational therapy assistant #1 talked with the resident and stated she would report it to the	F 309	resident #28 was immediately educated on timely pain medication administration and prioritization. **ID Of Others** Any resident who experiences pain is identified as being at risk therefore pain assessments were completed on every resident residing in the facility. **Systemic Changes** Education provided to all LN staff on pain management policy by DNS/Designee. Furthermore charts will be monitored in morning clinical meeting for efficiency of pain medication delivery and effectiveness. DON/Designee will audit pain flow sheets weekly x 4 weeks and monthly x 3 to ensure pain assessment documentation occurs prior to medication administration and after with effectiveness. **Monitoring** The Results will be brought to QAPI monthly for determination of need/frequency of on-going monitoring. Furthermore education regarding facility policy of pain management and assessment of pain levels before and after medication administration will be provided will be provided for all new hire licensed nursing staff during orientation. **Addressing #3 and #4** **Corrective Action** Resident #29 and #26 received a pain assessment and documented effectiveness of pain medication since received to ensure adequate relief is being met. **ID Of Others** Any resident who experiences pain is identified as being at risk therefore pain assessments were completed on every resident residing in the facility.	

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F 309	Continued From page 4 charge nurse. At 10:45 AM, the resident told CNA #3 and CNA #4 about wanting something for the pain in his/her hands when the CNAs provided toileting assistance. At 11:35 AM the resident sat in the wheelchair in the dining room and rubbed his/her hands together. At that time CNA #3 asked the resident about pain and departed to report this to the charge nurse. At 11:38 AM LPN #1 assessed the resident's pain level was "10" and administered the pain medication (over an hour after the resident requested it). At that time the LPN stated she was aware of the request for pain medication, but was busy providing care for other residents and could not respond to the request earlier. 3. Review of the care plan, updated 6/21/16, showed one of the problems for resident #29 was pain. Further review revealed the goal for this problem was for the resident to experience relief or decrease of pain within 30-60 minutes of administration of pain medication. Review of the physician orders showed Norco 5/325 mg every 6 hours prn was ordered on 11/12/15. Review of the July 2016 medication administration record revealed the resident received the medication daily. Further review revealed no documented pain assessment before or after the medication was administered.	F 309	**Systemic Changes** Education provided to all LN staff on pain management policy by DNS/Designee. Furthermore charts will be monitored in morning clinical meeting for efficiency of pain medication delivery and effectiveness. DON/Designee will audit pain flow sheets weekly x 4 weeks and monthly x 3 to ensure pain assessment ,documentation occurs prior to medication administration and after with effectiveness. **Monitoring** The Results will be brought to QAPI monthly for determination of need/frequency of on-going monitoring. Furthermore education regarding facility policy of pain management and assessment of pain levels before and after medication administration will be provided will be provided for all new hire licensed nursing staff during orientation. Compliance Date: 8/10/16	
	4. Review of the quarterly MDS dated 5/16/16 showed resident #26 had diagnoses that included history of falls, fracture of the ileum, and non-Alzheimer's dementia. Review of the pain care plan showed the resident had moderate pain frequently and interventions included administration of pain medications as ordered by the physician, and evaluate the resident for effectiveness of routine and PRN (as needed)			

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F 309	Continued From page 5 medications every shift. The following concerns were identified: a. Review of the pain management flowsheet for June 2016 showed the resident received 1 tablet of Norco 7.5 mg/325 mg on 6/17/16 and 6/19/16. The pain scale rating at the time of administration was 7; however, there was no evidence that the effectiveness of the pain medication was assessed after administration. b. Review of the June 2016 medication administration record showed the resident received 1 tablet of Norco 7.5 mg/325 mg on 6/25, 6/26, 6/27, 6/28, 6/29, and 6/30/16. There was no evidence that the pain level was assessed prior to medication administration and there was no evidence the effectiveness of the pain medication was assessed after administration. c. Interview with the DON on 7/14/16 at 9 AM revealed the pain level should have been assessed prior to administration and medication effectiveness should have been assessed after administration.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of temperature logs,	F 323		

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F 323	Continued From page 6 the facility failed to ensure safe water temperatures in 4 of 4 hallways. In addition, the facility failed to implement interventions to prevent falls for 1 of 7 sample residents (#19) with a history of falls. The findings were: Regarding water temperatures: 1. Observation of the 100 Hall on 7/13/16 showed the following: a. At 12 PM the temperature of the bathroom sink hot water in room 102 measured 129 degrees Fahrenheit (F). b. At 12:02 PM the temperature of the bathroom sink hot water in room 104 measured 123 degrees F. c. At 12:03 PM the temperature of the bathroom sink hot water in room 105 measured 130 degrees F. d. At 12:06 PM the temperature of the bathroom sink hot water in room 103 measured 122.2 degrees F. 2. Observation of the 200 hall on 7/13/16 showed the following: a. At 11:57 AM the temperature of the bathroom sink hot water in room 218 measured 126 degrees F. b. At 11:58 AM the temperature of the bathroom sink hot water in room 203 measured 123.6 degrees F. 3. Observation of the 300 hall on 7/13/16 showed the following: a. At 11:38 AM the temperature of the bathroom sink hot water in room 301 measured 129 degrees F. b. At 11:40 AM the temperature of the bathroom sink hot water in room 305 measured	F 323	**F 323 483.25(h) Free of Accident Hazards/Supervision/Devices** **Corrective Action** Water temps of bathroom sinks in rooms 102, 104, 105, 103 ,218, 203, 301, 305, 304, 402, 411, 408, 412, and 416 were established to not exceed 110 degrees Fahrenheit. New temperature control valves have been installed on the two main boilers. **ID Of Others** All bathroom water temps has been checked and verified for appropriate temperature range in the facility by the ED/Designee. **Systemic Changes** During facility construction the ED/Designee will select random bathrooms and audit water temperatures for appropriate range daily. **Monitoring** The Results will be brought to QAPI monthly for determination of need/frequency of on-going monitoring.	

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F 323	Continued From page 7 123 degrees F. c. At 11:42 AM the temperature of the bathroom sink hot water in room 304 measured 129.6 degrees F. 4. Observation of the 400 hall on 7/13/16 showed the following: a. At 11:45 AM the temperature of the bathroom sink hot water in room 402 measured 131.2 degrees F. b. At 11:46 AM the temperature of the bathroom sink hot water in room 411 measured 129.4 degrees F. c. At 11:47 AM the temperature of the bathroom sink hot water in room 408 measured 131.2 degrees F. d. At 11:50 AM the temperature of the bathroom sink hot water in room 412 measured 127 degrees F. e. At 11:54 AM the temperature of the bathroom sink hot water in room 416 measured 122 degrees F. 5. Observation on 7/13/16 between 3:15 PM and 3:41 PM showed the maintenance director checked the bathroom sink hot water temperatures for the above listed rooms and the temperature remained above 120 degrees F. The lowest temperature at that time was 126.5 degrees and the hottest temperature was 130.8 degrees F. Interview at that time revealed the construction to the kitchen may have been the cause of the elevated temperatures; however, he was unsure of the root cause. Further, it was confirmed that the water temperatures were too hot for resident use. Regarding falls:	F 323		

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F 323	Continued From page 8 1. Review of the 6/3/16 annual MDS assessment revealed resident #19 had two falls since the previous assessment. Review of a 4/29/16 IDT Fall Review showed the resident fell forward out of the wheelchair (w/c). The IDT conclusion was that the resident was to be in a common area when up in the w/c; otherwise the resident was to be in bed per family request. Review of a 6/2/16 IDT Fall Review showed the resident rolled out of bed. The IDT conclusion was to change the call light button to a pressure pad call light. Review of the IDT Fall Review dated 6/4/16 revealed the resident was found sitting on the floor in front of the w/c. The IDT conclusion was to educate staff that the resident was not to be left up in the w/c when in the room. Review of the care plan for the resident showed an update dated 5/2/16 which instructed staff to keep the resident in a common area when up in the w/c; otherwise the resident was to be in bed when in his/her room. In addition, on 6/2/16 the care plan was updated to include instructions to change the call light button to a pressure pad call light. The following concerns were identified: a. Observation on 7/12/16 at 9:50 AM revealed CNA #1 and CNA #2 assisted the resident to the bathroom. Afterwards, the CNAs left the resident in the w/c in his/her room. In addition, observation at that time revealed the call light was a button type, and not a pressure pad. b. During an interview on 7/13/16 at 4:36 PM the DON stated staff should not have left the resident in the w/c in his/her room; she stated the resident was to be in bed or the recliner when left in the room. In addition, she stated the resident should have a pressure pad call light.	F 323	**Regarding Falls:** 1. **Corrective Action** A pressure pad call light has been placed in the room of resident #19. Resident #19's plan of care regarding placement for safety has been reviewed with staff and implemented accordingly. **ID Of Others** A 100% facility audit was conducted by DON/Designee of all residents care plans to ensure identified interventions are accurate and are being carried out accordingly. **Systemic Changes** DON/Designee will conduct in-service with LN staff to emphasize importance of following established care plans. DON/Designee will conduct random weekly audits x 4 weeks and monthly x 3 to ensure care plans are followed with services provided. **Monitoring** Results of audits conducted will be brought to QAPI monthly for determination of need/frequency of on-going monitoring. All new hire licensed nursing staff will receive education during orientation on the importance of following all written plans of care for residents. Compliance Date: 8/10/16	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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SAGE VIEW CARE CENTER	1325 SAGE STREET ROCK SPRINGS, WY 82901

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F 329	Continued From page 9 Each resident's drug regimen must be free from 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, staff and resident interview, and review of resident council documentation and policy and procedure, the facility failed to ensure the medication regimen was free of unnecessary drugs for 1 of 7 residents (#29) who required behavioral monitoring. The findings were: Review of the 6/17/16 quarterly MDS for resident #29 revealed diagnoses included anxiety disorder	F 329	**F 329 483.25(i) Drug Regimen is Free From Unnecessary Drugs** **Addressing A., B., and C.** **Corrective Action** Resident #29 medications were reviewed by IDT and physician for appropriateness and targeted behaviors identified for PRN Vistaril. Physician has elected to continue medication. Behavior flow sheet has been updated with targeted behaviors, pharmacological and non-pharmacological interventions with effectiveness and any behaviors currently being exhibited. **ID Of Others** Any resident with PRN medications requiring behavior monitoring and evaluation for effectiveness is at risk. A audit has been conducted by social services/designee on all residents receiving a psychoactive medication for justification, effectiveness and review for gradual dose reduction. **Systemic Changes** Licensed Nursing staff have been educated by social services/designee on documentation of targeted behaviors before administration of PRN psychoactive medication and documentation of effectiveness of interventions used. Random audits will be conducted weekly x 4 weeks and monthly x 3 months by social services/designee on PRN psychoactive medications ordered on residents to monitor behavior sheet completion, IDT review for dose reduction and justification, as well as effectiveness of interventions for targeted behaviors.	

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F 329	Continued From page 10 and dementia. Further review revealed the resident had moderately impaired cognition, wandering 1 to 3 days weekly, and fluctuating behaviors that included inattention, disorganized thinking, altered level of consciousness, and psychomotor retardation. Review of the 6/21/16 care plan showed interventions were developed to address anxiety, intrusive wandering, aggressive outbursts, physical aggression, sleep disturbances, irritability, socially inappropriate behavior, and involvement in resident to resident altercations. This review revealed the interventions included monitor behavior and assess weekly and monthly, recommend medication reductions to the IDT team, and assess/monitor agitation, hitting, kicking, and refusing care and medications. Review of the May, June, and July 2016 nurses' notes showed the following documented behaviors: resident-to-resident altercation on 5/7/16, attempt to exit the building on 5/9/16, pacing and entering other resident rooms on 5/10/16, intrusive wandering on 5/12/16, another resident reported being hit by resident #29 on 5/29/16, resident #29 was "up 1/2 the night" on 5/12/16, refused to go into his/her room on 6/3/16, wandering on 6/4/16, wandering in other resident rooms and borrowing things on 6/5/16, resident-to-resident altercation on 6/13/16 and again on 6/15/16, and pacing on 6/28/16. Review of a resident council response form dated 5/24/16 revealed residents complained about other residents wandering in and out of their rooms. The follow-up dated 6/21/16 showed residents still felt it was a concern. An interview on 7/12/16 at 2:30 PM with 12 residents revealed the residents were concerned about the	F 329	**Monitoring** Results of audits conducted will be brought to QAPI monthly for determination of need/frequency of on-going monitoring. All new hire licensed nursing staff will receive education during orientation on documentation required for justification of psychoactive medications including behavior flow sheet, pharmacist review, and effectiveness of psychoactive medications. **Addressing D.** **Corrective Action** Resident #29's physician was notified of recommendation to restart Ativan with declination order received. **ID Of Others** Any resident with PRN medications requiring behavior monitoring and evaluation for effectiveness is at risk. A audit has been conducted by social services/designee on all residents receiving a psychoactive medication for justification, effectiveness and review for gradual dose reduction. **Systemic Changes** Licensed Nursing staff have been educated by social services/designee on documentation of targeted behaviors before administration of PRN psychoactive medication and documentation of effectiveness of interventions used. Random audits will be conducted weekly x 4 weeks and monthly x 3 months by social services/designee on PRN psychoactive medications ordered on residents to monitor behavior sheet completion, IDT review for dose reduction and justification, as well as effectiveness of interventions for targeted behaviors.	

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F 329	Continued From page 11 wandering of resident #29. They stated s/he wanders into their rooms and has had aggressive behavior. Review of the May, June and July 2016 physician's orders showed prn Ativan was discontinued on 5/10/16, and Vistaril 25 mg every 8 hours prn (as needed) was ordered. According to the May, June, and July 2016 medication administration records the prn Vistaril was ordered for anxiety/agitation; and the two scheduled medications for behavioral disturbance, Donepezil and Depakote, remained unchanged after 5/18/16. The following concerns were identified: a. Review of the policy and procedure for behavior management, updated September 2014, showed staff were directed to complete the Behavior Monitor Flowsheet as the indicated behaviors were exhibited. Review of the May, June, and July 2016 Behavior Monitor Flowsheets revealed all were blank. Interview with the DON on 7/12/16 at 1:30 PM revealed staff "charted by exception"; the blank flowsheets meant there were no behaviors; and sometimes, behaviors were documented in the nurses' notes. Review of the May, June, July 2016 nurses' notes showed documentation was lacking regarding identified behaviors, effective and ineffective non-pharmacological and pharmacological interventions that were used to address the behaviors, and precipitating factors. b. Interview with the social services director on 7/13/16 at 3:50 PM revealed the resident's behaviors and medications were reviewed as needed by the IDT members and documented on the Behavior Medication Review Form. Review of the medication review forms revealed there were 3 meetings from 5/11/16 to 7/11/16. This review	F 329	**Monitoring** Results of audits conducted will be brought to QAPI monthly for determination of need/frequency of on-going monitoring. All new hire licensed nursing staff will receive education during orientation on documentation required for justification of psychoactive medications including behavior flow sheet, pharmacist review, and effectiveness of psychoactive medications. Compliance Date: 8/10/16	

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F 329	Continued From page 12 showed the meeting dates were 5/12/16, 6/3/16 and 6/22/16; the behaviors increased; and the medications reviewed were Zoloft for treatment of depression and Depakote used for behavioral or psychological symptoms of dementia (both were scheduled daily medications). Further review revealed prn Vistaril had not been included in the medication review. c. Review of the May, June, and July 2016 medication administration records showed no documented reason for use or effectiveness of Vistaril administered 11 times from 5/20/16 to 5/31/16, 29 times in June 2016, and 9 times from 7/1/16 to 7/12/16. d. Review of the 6/22/16 Medication Review Form showed the IDT members recommended restart Ativan because the resident's behaviors had not improved. Review of the medical record on 7/13/16 revealed the medication had not been ordered (3 weeks later). Interviews on 7/13/16 with the social services director at 3:50 PM and the DON at 5:40 PM revealed the pharmacist supported the recommendation, but no one followed up to ensure the physician ordered the medication.	F 329		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing	F 353	**F 353 483.20(a) Sufficient 24-HR Nursing Staff Per Care Plans** 1. **Corrective Action** resident #20 call light was answered and needs was meet. **ID Of Others** Call light audits were conducted for all shifts at random for identification of response time. **Systemic Changes** An in-service was conducted by DON/designee with all staff	

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F 353	Continued From page 13 care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, review of staffing schedules and resident council forms, and resident, family, and staff interviews, the facility failed to ensure adequate staffing on the evening/night shift to ensure timely response of call lights on 2 of 3 units (Rehab, Frontier). The census was 43. The findings were: 1. Observation on the evening shift on 7/11/16 at 7:45 PM revealed resident #20 put on his/her call light. At 8:05 PM (20 minutes) CNA #5 answered the call light, and assisted the resident with getting ready for bed. Interview with the resident at 8:40 PM revealed 20 minutes was actually pretty quick for call light response on the evening shift. She stated there was decreased staff on the evening shift compared to the day shift, and call lights took longer to answer. 2. Review of a 5/24/16 resident council response form showed residents were concerned that CNAs turn off call lights and say they will be right back, but they don't come back to provide assistance. The follow-up dated 6/21/16 revealed	F 353	regarding timely response to answering call lights. ED/Designee will conduct random call light audits weekly x 4 weeks and monthly x 3 months to ensure timely call light response time. **Monitor** Results of audits conducted will be brought to QAPI monthly for determination of need/frequency of on-going monitoring. All new hire licensed nursing staff will receive education during orientation on timely call light response. 2. **Corrective Action** All staff received education by the DNS/Designee on not turning off call lights until the residents needs have been meet . **ID Of Others** Call light audits were conducted for all shifts at random for identification of response time and needs met. **Systemic Changes** All staff received education on answering call lights. ED/Designee will conduct random call light audits weekly x 4 weeks and monthly x 3 months to ensure timely call light response time and needs are met. . **Monitor** Results of audits conducted will be brought to QAPI monthly for determination of need/frequency of on-going monitoring. All new hire licensed nursing staff will receive education during orientation on timely call light response.	

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F 353	Continued From page 14 residents still felt call lights were a problem. 3. During an interview on 7/12/16 at 2:30 PM, 12 of 12 residents stated staffing was a problem. The residents stated staffing levels dropped off in the evenings. They stated call lights took a long time to answer because of inadequate staff on the evening shift. 4. During a confidential interview on 7/11/16 at 6:35 PM family member #1 stated staffing in the evenings was inadequate, for both CNAs and nurses. She stated sometimes at night there was only one CNA for all the hallways outside the secure care unit. Confidential interview on 7/11/16 at 6:40 PM with family member #2 revealed at times staff appeared short tempered because they are "short staffed." Further, it was revealed the staff don't have time to do everything and the call lights don't get answered timely. 5. Interview with CNA #5 on 7/11/16 at 8:15 PM revealed there was less staff to assist residents to bed because there was usually 1 CNA on each hall after 6 PM. 6. Interview with CNA #5 on 7/12/16 at 12:16 AM revealed the facility had 2 CNAs and 1 nurse for the entire facility from 10:30 PM until midnight on 7/11/16. 7. Review of staffing sheets showed the following: a. Review of staffing sheets for May 2016 showed the facility had 3 or less CNAs on duty for the entire building from 6 PM to 10 PM 12 out of 31 days. Further, from 10 PM to 6 AM the facility had 2 CNAs for the entire building 13 out of 31	F 353	**Addressing #3, #4, #5, #6, and #7 Corrective Active** Through audits conducted and interviews with residents evening shift was identified to be in need of additional assistance. **ID of Others** Call light audits were conducted for all shifts at random for identification of response time and needs met. . **Systemic Changes** All staff received education on answering call lights and appropriate staffing matrix ratios based upon census and resident acuity. ED/Designee will conduct random call light audits weekly x 4 weeks and monthly x 3 months to ensure timely call light response time and needs are met. . **Monitor Results** of audits conducted will be brought to QAPI monthly for determination of need/frequency of on-going monitoring. All new hire licensed nursing staff will receive education during orientation on timely call light response. Compliance Date: 8/10/16	

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F 353	Continued From page 15 days. b. Review of the staffing sheets for June 2016 showed the facility had 3 or less CNAs on duty for the entire building from 6 PM to 10 PM 6 out of 30 days. Further, from 10 PM to 6 AM the facility had 2 CNAs for the entire building 5 out of 30 days. c. Review of the 2016 staffing sheets for July 1 through July 11, showed the facility had 3 or less CNAs on duty for the entire building from 6 PM to 10 PM 2 out of 11 days. Further, from 10 PM to 6 AM the facility had 2 CNAs for the entire building 2 out of 11 days. 8. Interview with the DON and administrator on 7/14/16 at 9:55 AM revealed the facility having 1 nurse and 2 CNAs for the entire building at night was not a good ratio and presented safety concerns. Further, it was revealed the facility had a difficult time obtaining staff for the night shift.	F 353	F 387 483.40(c)(1)-(2) Frequency and Timeliness of Physician Visit 1. **Corrective Action** Resident #26 will be seen by the physician on 8/1/16. **ID Of Others** all charts were audited on 7/15/16 to determine most recent physician visit **Systemic Changes** Medical records and/or designee will audit charts to meet the following requirements of physicians visits; once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. The facility will ensure the residents are seen by their physician's in a timely manner. Medical Records/designee will audit charts weekly x 4 weeks and monthly x 3 to ensure timely visits. **Monitor** Results of audits conducted will be brought to QAPI monthly for determination of need/frequency of on-going monitoring.	
F 387 SS=E	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure residents were seen by a physician at least once every 60	F 387	2. . **Corrective Action** Resident #29 was seen by the physician on 7/26/16. **ID Of Others** all charts were audited on 7/15/16 to determine most recent physician visit. **Systemic Changes** Medical records and/or designee will audit charts to meet the following requirements of physician's visits; once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. The facility will ensure the residents are seen by their physician's in a timely manner. Medical Records/designee will audit charts weekly x 4 weeks and monthly x 3 to ensure timely visits. **Monitoring** Results of audits conducted will be brought to QAPI monthly for determination of need/frequency of on-going monitoring.	

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F 387	Continued From page 16 days for 4 of 11 sample residents (#4, #5, #26, #29). The findings were: 1. Review of the physician visit notes showed resident #26 had a physician visit on 7/16/15. There was no evidence that the resident was seen by a physician again until 5/25/16, 314 days later. 2. Review of the medical record showed resident #29 was admitted on 5/19/15 and the dates of the physician visits were 6/22/15, 8/13/15, 10/27/15, and 3/2/16. 3. Review of the medical record showed resident #5 was admitted on 5/19/15. The only documentation of a physician visit was 7/16/15. 4. Review of the medical record showed resident #4 was admitted on 5/19/15 and the dates of the physician visits were 10/20/15 and 3/23/16. 5. Interview with the DON on 7/14/16 at 9 AM revealed the facility was unable to obtain documentation of physician visits.	F 387	3. **Corrective Action** Resident #5 will be seen by a physician on 8/1/16. . **ID Of Others** All charts were audited on 7/15/16 to determine most recent physician visit. **Systemic Changes** Medical records and/or designee will audit charts to meet the following requirements of physician's visits; once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. The facility will ensure the residents are seen by their physician's in a timely manner. Medical Records/designee will audit charts weekly x 4 weeks and monthly x 3 to ensure timely visits. **Monitoring** Results of audits conducted will be brought to QAPI monthly for determination of need/frequency of on-going monitoring. 4. **Corrective Action** Resident #4 has been seen by a physician on 7/14/16. **ID Of Others** all charts were audited on to determine most recent physician visit. **Systemic Changes** Medical records and/or designee will audit charts to meet the following requirements of physician's visits;	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate	F 425	once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. The facility will ensure the residents are seen by their physician's in a timely manner. Medical Records/designee will audit charts weekly x 4 weeks and monthly x 3 to ensure timely visits. **Monitoring** Results of audits conducted will be brought to QAPI monthly for determination of need/frequency of on-going monitoring. Compliance Date: 8/10/16	

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F 425	Continued From page 17 acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to ensure expired medications were not available for administration in 2 of 4 medication storage areas (Rehab medication cart, Frontier medication cart), and failed to ensure narcotic medications were stored appropriately in 1 of 4 narcotic storage areas (medication refrigerator). The findings were: Regarding expired medications: 1. Observation of the "Frontier" medication cart on 7/14/16 beginning at 7:45 AM showed the house stock bottle of aspirin 81 mg had an expiration date of 5/16. Further, non-sample resident #34 had the following expired prescription medications: Ramipril 5 mg with an expiration date of 2/2/16, Ramipril 5 mg with an expiration date of 3/31/16, carvedilol 6.25 mg with an expiration date of 7/6/16, and furosemide 20 mg with an expiration date of 2/2/16. 2. Observation of the "Rehab" medication cart on 7/14/16 beginning at 7:30 AM showed the house	F 425	F 425 483.60(a),(b) Pharmaceutical Svc-Accurate Procedures **Regarding Expired Meds** **Corrective Action** The expired medications identified of Aspirin, Rampril, Carvedilol and Furosemide were immediately removed from cart upon finding on 7/14/2016. **ID Of Others** The DON/designee competed a 100% audit of all medication carts and all expired meds have been removed. **Systemic Changes** Education has been provided to LN staff on 7/28/16 regarding removal of expired medication and check for expiration date before medication administration. DON/Designee will audit medication carts weekly x 4 weeks and monthly x 3 to ensure all expired medications have been removed. **Monitor** Results of audits conducted will be brought to QAPI monthly for determination of need/frequency of on-going monitoring. All new hire licensed nursing staff will receive education during orientation on medication expiration checks prior to administration. **Regarding Narcotic Storage:** **Corrective Action** A new lock was immediately placed on the medication storage refrigerator. **ID Of Others** DON/Designee audited all other medication storage refrigerators to ensure locks are in good working order. **Systemic Changes** the medication storage refrigerator will be moved into a locked room	

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F 425	Continued From page 18 stock bottle of aspirin 81 mg had an expiration date of 3/16. 3. Interview with RN #2 on 7/14/16 at 8:03 AM revealed that the medications were still in use and confirmed they were all expired. 4. Interview with the DON on 7/14/16 at 9 AM revealed that expired medications should not be available for administration to residents. 5. Review of the policy titled "Disposal/Destruction of Expired or Discontinued Medications" last revised on 1/1/13 showed "...Procedure:...4. Facility should place all discontinued or out-dated medications in a designated, secure location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction...8. Facility should dispose of discontinued medication, out-dated medications, or medications left in the facility after a resident has been discharged in a timely fashion, or no more than 90 days of the date the medication was discontinued by Physician/Prescriber, or sooner per applicable law..." Regarding narcotic storage: 1. Observation on 7/12/16 at 7:30 PM revealed the lock on the medication storage refrigerator door was broken. At that time LPN #2 confirmed the locked box of narcotics and scheduled II medications was stored in this refrigerator. Further observation revealed the refrigerator was located at the nurses' desk and easily accessible to others when staff were not present at the nurses' desk area. At that time the LPN stated the lock had been broken for two days and she did	F 425	that only the RN and LPN will have access to. DNS/Designee will conduct weekly audits x 4 weeks and monthly x 3 months to ensure locks on the medication storage refrigerators remain in place and in good working order.. Monitor Results of audits conducted will be brought to QAPI monthly for determination of need/frequency of on-going monitoring. All new hire licensed nursing staff will receive education during orientation on medication storage regulations and safety. Compliance Date: 8/10/16	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535056	A. BUILDING _____ B. WING _____	C 07/14/2016

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F 425	Continued From page 19 not know when it was scheduled to be repaired. 2. Review of Policy #5.3, titled "Storage and Expiration of Medications, Biologicals, Syringes and Needles,", showed "...Facility should ensure that all medications and biological, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by resident and visitors."	F 425		
F 441 SS=D	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 (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	F 441	**F 441 483.65 Infection Control, Prevent Spread, Linens** **Regarding Random Observation:** **Corrective Action** C.N.A #6 has been provided education by the DON/Designee on infection control, preventing spread of infection and proper handling of linens.. **ID Of Others** Any resident receiving staff assistance with ADL's in the facility is potentially at risk. The DON/Designee will conduct random C.N.A observations to ensure proper procedures are followed regarding personal care and infection control. **Systemic Changes** The DON/Designee will conduct 3 random C.N.A observations audits weekly x 4 weeks and monthly x 3 months to ensure proper procedures are followed regarding personal care and infection control. Education has been provided to LN staff regarding infection control and providing personal care by the DON/Designee. **Monitor** Results of audits conducted will be brought to QAPI monthly for determination of need/frequency of on-going monitoring. All new hire licensed nursing staff will receive	

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F 441	Continued From page 20 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, medical record review, staff interview, and review of manufacturer's recommendations, the facility failed to ensure infection prevention practices were implemented during 1 random observation which affected 1 sample resident (#33). In addition, the facility failed to utilize effective sanitation techniques for 1 of 1 sample resident (#36) with a clostridium difficile (C-Diff) infection. The findings were: Regarding random observation: 1. Observation on 7/11/16 at 4:29 PM showed CNA #6 assisted resident #33 into the wheelchair. Prior to the transfer, the resident's catheter drainage bag and oxygen tubing was laying on the floor. The CNA applied gloves and picked the oxygen tubing up off the floor and placed it in a bag on the back of the wheelchair. The CNA then removed the resident's pants at which time she was holding the resident's catheter drainage bag and put it through the leg hole of the pants. After removing the pants, the CNA went to the resident's closet and obtained a clean shirt and pants. While applying the clean pants, the CNA picked up the catheter bag and raised it to chest	F 441	education during orientation on infection control and proper handling of linens. **Regarding C-Diff Infection:** **Corrective Action** The facility immediately cleaned room #36 with proper solution for clostridium difficile (i.e. bleach) and provided education to the housekeeping staff regarding proper solution needed for c-diff isolation rooms. **ID Of Others** All residents are potentially at risk of spread of infection. No other residents have been identified with a C-Diff. infection. **Systemic Changes** All staff received education regarding how to clean a room that has a resident who is C-Diff positive by the DON/Designee.. Housekeeping supervisor/designee will conduct weekly audits x 4 weeks and monthly x 3 months to ensure effective sanitizing techniques for residents with infections requiring isolation are being cleaned with appropriate technique and solution. **Monitor** Results of audits conducted will be brought to QAPI monthly for determination of need/frequency of on-going monitoring. All new hire licensed nursing staff will receive education during orientation on infection control policy and procedure including isolation. Compliance Date: 8/10/16	

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F 441	Continued From page 21 level, above the resident's bladder, allowing urine visible in the tubing to flow backwards toward the resident's bladder, while she placed the drainage bag through the pant leg of the clean pants. After applying the clean pants, the CNA hung the drainage bag on her pants pocket and assisted the resident to sit on the side of the bed at which time she applied the residents clean shirt. The CNA then assisted the resident to stand and transfer into the wheelchair. At that time, the CNA removed the drainage bag from her pants and attached it to the resident's wheelchair. The CNA obtained the oxygen tubing from the bag on the wheelchair and applied it to the resident. The gloves and oxygen tubing were not changed prior to applying the tubing. 2. Interview with the DON on 7/14/16 at 9 AM revealed the catheter should not have been lifted above the resident's bladder because it could increase the resident's risk for infection. Further, it was revealed the staff member should have removed gloves prior to touching clean items, to prevent cross-contamination and new oxygen tubing should have been obtained after the tubing was on the floor. Regarding C-Diff infection: 1. Review of a nurse's note dated 6/30/16 and timed 4:30 PM showed resident #36 returned from the hospital with diagnoses that included "C-Diff toxic." Review of laboratory result 6/27/16 revealed the resident had a stool specimen that was obtained on 6/26/16 and tested positive for "Toxigenic C.difficile." Review of the "Contact Precaution Care Plan" dated 6/30/16 showed interventions that included "devices are wiped with bleach" and "housekeeping to clean per	F 441		

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F 441	Continued From page 22 policy." The following concerns were identified: a. Interview with CNA #7 on 7/13/16 at 11:20 AM revealed that after use of the toilet, staff wiped the toilet down with disinfectant cleaner. b. Interview with housekeeper #1 on 7/13/16 at 2:12 PM revealed the staff used 2 products called "8L and 5L" to clean resident #36's bathroom. Further, the staff sprayed on the cleaner and let it sit for "5 or 10 minutes" then wiped it off. The staff member was not aware of any special cleaning at that time. c. Review of the "5L" manufacturer's recommendations received from the facility on 7/13/16 showed the cleaner was not effective against the clostridium difficile bacteria. d. Review of the "8L" manufacturer's recommendations received from the facility on 7/13/16 showed the cleaner was not effective against the clostridium difficile bacteria. e. Interview with the housekeeping supervisor on 7/13/16 at 3:05 PM revealed cleaning with the "5L" or "8L" cleaning solution was not appropriate for resident #36's room because neither chemical is effective against clostridium difficile. Further, it was revealed the staff should have used a bleach solution.	F 441		