9/16/16

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

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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
	535039	A. BUILDING _____ B. WING _____	C 08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW HEALTH CARE CENTER	1990 WEST LOUCKS STREET SHERIDAN, WY 82801

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 8/1/16 through 8/4/16. Additionally, complaint intake WY00002230 was reviewed during the course of this survey. The following common abbreviations are used throughout this document: ADLs: Activities of Daily Living CNA: Certified Nurse Aide DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and medical record review the facility failed to provide assistance to residents in making care choices for 1 of 16 sample residents (#6). The findings were:	F 242	F242 -Self Determination- right to make choices The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility and make choices about aspects of his or her life in the facility that are significant to the resident. 1. Resident #6 will be provided assistance in his right to choose the use of an electric wheelchair. Resident #6 will be evaluated by therapy to determine if he will be able to safely and appropriately maneuver an electric wheelchair both inside and outside of the facility. 2. All residents will be provided assistance in making care choices. The Activity Director will in-service	9-16-16

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

Tonya M — Executive Director — 9-9-16 (revised)

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.

Accepted on 9/16/16 by Loralee Russ Tonya Miner, NHA notified

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F 242	Continued From page 1 1. Review of the 7/8/16 quarterly MDS assessment showed resident #6 had diagnoses which included chronic obstructive pulmonary disease, cardiovascular disease, Parkinson's disease, and post traumatic stress disorder. Further, the resident had a Brief Interview for Mental Status score of 11/15 which indicated moderate impairment, was understood and was able to understand, required set up help of 1 staff member for locomotion in a wheelchair, and required oxygen. The following concerns were identified: a. Interview with the resident on 8/1/16 at 4:14 PM revealed that s/he was having trouble obtaining an electric wheelchair and was prepared to purchase it with his/her own money. b. Review of a Social Service (SS) note dated 8/20/15 revealed that SS was contacted by the resident's son related to obtaining an electric wheelchair for the resident. c. Interview on 8/3/16 at 3:50 PM with the executive director, DON, and social service director revealed they were concerned with the resident having an electric wheelchair due to his/her aggressive tendencies and felt it was a safety issue. They stated that s/he had not been involved in any resident to resident altercations, had not been evaluated by physical therapy, and had not been given an opportunity to try an electric wheelchair. d. Review of the medical record revealed no documentation that an evaluation had been done. e. Interview with the resident on 8/4/16 at 8:50 AM revealed an electric wheelchair would allow him/her to be more independent, go outside to sit and/or participate in activities. Further, s/he stated using a manual wheelchair was not worth it because of the frequent rests needed and asking for help was a hassle.	F 242	Resident Council at the next meeting on their right of self-determination in making care choices. They will also be in-serviced on the use of the concern and comment program to report any requests or grievances regarding their right to self-determination in making choices about their care. Staff will be in-serviced by the Executive Director to report to Social Services using the concern and comment card program, any resident request or grievance regarding their right to self-determination in making care choices. 3. The Executive Director will conduct an audit of the concern and comment program to ensure those residents making requests or grievances regarding their care choices are being assisted by staff. 4. Results of these audits will be reviewed at the Performance Improvement meetings monthly for three months or until the committee is able to determine the process in place is effective. Performance Improvement meetings consistent of at a minimum the Executive Director, Director of Nursing, and Medical Director, and additional staff as needed. The Performance Improvement committee identifies 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.	

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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 provide a sanitary and well-maintained environment in 3 of 3 resident units (Southfork, Pioneer, Saddle Ridge). The findings were: 1. Observation on 8/3/16 at 10:30 AM showed the bathroom in room 108 had 2 gouges 12 inches up from the floor that measured 14 inches by 1 inch and 12 inches by 1 inch. Further, there was a gouge in the wall outside of the bathroom that was 10 inches up from the floor and measured 2 inches by 1 inch. The gouges exposed the underlying drywall which created an unsanitizable surface. 2. Observation on 8/3/16 at 10:32 AM showed the bathroom in room 105 had a gouge 12 inches up from the floor that measured 8 inches by 1/2 inch and exposed the underlying drywall which created an unsanitizable surface. 3. Observation on 8/3/16 at 11:20 AM showed the "Southfork" shower room had 20 tiles that measured 2 inches by 2 inches and were cracked or chipped which created an unsanitizable surface. 4. Observation on 8/3/16 at 10:42 AM showed the bathroom in room 201 had a gouge 12 inches up	F 253	F 253—Housekeeping and Maintenance Services The facility must provide housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior. 1. An inspection of the facility was completed by the Maintenance Director and ED to ensure all areas were cleaned/fixed/ repaired. The damaged walls in rooms #108, #105, #201, #213, #211, #and #313 were repaired and repainted. A protective plate will be installed in bathroom corners to ensure wall will remain intact. The bathroom flooring in room #208 has been replaced. The tiles in the "Southfork" shower room have been repaired with epoxy to ensure a cleanable surface. The door in the "Pioneer" shower room will be repaired and covered with a protective sheet to ensure it remains in good repair. 2. The Maintenance Director will conduct a 100% audit of the facility to ensure walls, flooring and doors remain in good repair. 3. All Staff will be in-serviced on submitting maintenance requests to the Maintenance Director regarding the damage of walls, flooring or doors throughout the facility. The Maintenance Director will conduct random monthly audits for three months to ensure walls, flooring, and doors remain in good repair.	

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F 253	Continued From page 3 from the floor that measured 12 inches by 1/2 inch and exposed the underlying drywall which created an unsanitizable surface. 5. Observation on 8/3/16 at 10:46 AM showed the bathroom in room 213 had 2 gouges 12 inches up from the floor that measured 17 inches by 1/2 inch and 15 inches by 1 inch. The gouges exposed the underlying drywall which created an unsanitizable surface. 6. Observation on 8/3/16 at 10:50 AM showed the bathroom in room 208 had an area on the floor that measured 42 inches by 47 inches with multiple pits or chips that were black in color. The areas caused the floor to be unsanitizable. 7. Observation on 8/3/16 at 10:52 AM showed the bathroom in room 211 had a gouge 12 inches up from the floor that measured 13 inches by 1/2 inch and exposed the underlying drywall which created an unsanitizable surface. 8. Observation on 8/3/16 at 11:20 AM showed the "Pioneer" shower room had 3 damaged areas on the exit door that measured 4 inches by 1/2 inch, 1 inch by 1/2 inch, and 1/2 inch by 1/2 inch and exposed the underlying wood which created an unsanitizable surface. 9. Observation on 8/3/16 at 11:02 AM showed room 313 had gouges in the wall by the bed that measured 6 inches by 1/2 inch, 3 inches by 1/2 inch, and 2 inches by 1/2 inch and exposed the underlying drywall. The bathroom had a corner that was damaged 4 inches up from the floor and measured 8 inches which exposed the underlying metal. The damaged areas created an unsanitizable surface.	F 253	4. Results of these audits will be presented at the Performance Improvement meetings monthly for three months or until the committee is able to determine the process in place is effective.	

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F 253	Continued From page 4 10. Interview with the maintenance director on 8/4/16 at 8:25 AM revealed he was aware of some of the damaged areas; however, there was no plan or timeline to fix them. Further, it was confirmed that the areas could not be cleaned properly.	F 253		
F 278 SS=D	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 assessment. Clinical disagreement does not constitute a material and false statement.	F 278	F278 -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. 1. The MDS for resident #43 has been modified and resubmitted to reflect the fall on 3/29/16. 2. A 100% audit by the DON will be conducted of all residents who have had a fall in the last 30 days to determine if the MDS is accurate. 3. The Inter Disciplinary Team including the MDS Coordinator will be educated regarding the importance of accuracy when coding the MDS by the Clinical Reimbursement Specialist. The education will include the MDS Coordinator reviewing incidents as well as interviewing staff to determine if any falls have occurred to ensure falls have been accurately coded in the MDS. The DON/ED will conduct monthly random audits for three months of residents who have had a fall to ensure accuracy of MDS coding.	9-16-16

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F 278	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the accuracy of MDS assessments for 1 of 16 sample residents (#43). The findings were: Review of the quarterly MDS assessment with an Assessment Reference Date (ARD) of 4/14/16 revealed resident #43 had not had any falls since the previous assessment. However, review of progress notes showed on 3/29/16 the resident fell forward in the shower chair and hit his/her head on the shower wall. The resident was sent to the emergency room and was diagnosed with a nasal fracture. During an interview on 8/4/16 at 9:15 AM the DON confirmed the resident had a fall on 3/29/16 and stated the 4/14/16 MDS assessment was inaccurate for falls.	F 278	4. Results of these audits will be reported to the Performance Improvement committee monthly for three months or until the committee is able to determine the process in place is effective.	
F 318 S6=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure restorative nursing services were provided as planned for 1 of 5 sample residents (#36) with range of motion	F 318	F 318 - Increase/Prevent Decrease in Range of Motion Based on the comprehensive assessment of a resident, the facility must ensure that a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. 1. Resident #36 remains in facility and continues to receive restorative nursing services including range of motion per physician orders 2. An initial 100% audit will be completed by DON/Restorative Nurse of the Restorative Nursing program to ensure those residents are receiving restorative services as ordered. Random audits will be conducted weekly for three months of no fewer than 5 residents receiving restorative/range of motion services to ensure restorative services were provided as planned.	9-16-16

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F 318	Continued From page 6 (ROM) limitations. The findings were: 1. Review of the July 2016 restorative care record showed the treatment plan and frequency were not being met for resident #36. Review of the 5/26/16 initial MDS assessment showed the resident had ROM limitations on one side of the lower extremities. The plan showed the resident was to receive services two to three times per week which included maintaining and increasing strength in the upper extremities. Further, the plan showed the resident was to receive services two to five times per week which included maintaining and strengthening the lower extremities. The following concerns were identified: a. Review of the July 2016 record showed the plan for upper extremities was completed on 7/1, 7/7, 7/9, 7/14, 7/15, 7/16, 7/17, and 7/19. Further review showed the plan for the lower extremities was completed on 7/7, 7/9, 7/10, 7/14, and 7/19. Continued review showed the plan was not completed any day from 7/20 to 7/31. b. During interview with the restorative aide on 8/3/16 at 4:35 PM she stated "the resident was usually in bed when I went in to work with [the resident] and then I can't do the Omnicycle (arm exercise bike)". Further, the aide stated she was gone from the facility from July 20-26 and 29-31 and there was no one in the facility to function as back-up restorative aide. c. During an interview on 8/4/16 at 9:30 AM the administrator and DON stated the facility had identified restorative nursing as an issue, but it was not being addressed in their quality assurance program.	F 318	3. DON will educate the restorative nursing staff regarding the importance of providing restorative services as ordered as well as documentation compliance for all residents in any restorative nursing program, including range of motion services. DON will assign a designee as backup when the Restorative Aide is absent from the facility. 4. Results of the audits will be presented monthly at the Performance Improvement meeting for three months or until the committee is able to determine the process in place is effective.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371	F 371- Food Secure, 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	

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F 371	Continued From page 7 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 nutritional supplements were labeled with the correct expiration dates in 1 of 1 kitchens. The findings were: Observation of the reach-in refrigerator in the kitchen on 8/1/16 at 4:10 PM revealed 14 cartons (4 ounces each) of thawed vanilla shakes with an expiration date of 8/20 written on them. In addition, there were 3 cartons labeled with an expiration date of 8/17. Review of the product labeling on the shakes revealed they were to be used within 14 days of thawing. Interview with cook #1 on 8/1/16 at 4:20 PM confirmed the thawed shakes should be used within 14 days, and stated the dates of 8/17 and 8/20 were "too far out." Further interview with cook #1 on 8/2/16 at 5 PM revealed it was a new prep person who had put the wrong expiration dates on the shakes, and the facility had corrected the dates.	F 371	1. The health shakes in question were dated with the correct expiration dates immediately after discovery. 2. The Certified Dietary Manager completed a 100% audit of all health shakes to determine the accuracy of the expiration dates on 8/2/16. 3. Certified Dietary Manager will educate all dietary staff on the importance of writing the expiration date accurately upon food items opened or removed from the freezer. The Certified Dietary Manager will conduct a weekly audit of food items opened or removed from the freezer for one month then monthly for three months to ensure the dietary staff are compliant and accurate with using the appropriate expiration dates on all food items in the kitchen. 4. The results of these audits will be presented monthly at the Performance Improvement meeting for a period of three months and until the committee is able to determine the process in place is effective.	9-16-16
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be	F 428		

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F 428	Continued From page 8 reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the physician acted upon pharmacy recommendations for 3 of 13 sample residents (#20, #24, and #36). The findings were: 1. Review of the 7/28/16 quarterly MDS assessment showed resident #20 had diagnoses that included hyperlipidemia (elevated lipids [fats] in the blood), and a history of unhealed pressure ulcers. Review of the pharmacist recommendations form dated 6/21/16 showed the pharmacist had recommended the resident's lipid (a blood test to measure lipids) panel be checked due to the resident being on Simvastatin (prescription medication to lower cholesterol). Further review did not show the physician had addressed the pharmacist recommendation. Review of subsequent orders did not show an order for the laboratory test to be obtained. Continued review of the medical record showed the pharmacist requested a clarification of the diagnosis for the use of gabapentin (treatment for pain due to neuropathy) on 6/21/16. Further review did not show the physician had addressed the clarification request. Interview with the DON	F 428	F428 – Drug Regimen Review, Report Irregular, Act On The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. 1. Resident #20 no longer resides in the facility. The facility was able to obtain clarification for diagnosis for medications ordered for resident #24. Resident #36 had a HgbA1c drawn on 8/17/16. 2. DON will review all pharmacy recommendations in the last 30 days to ensure those recommendations have been completed. 3. An admission checklist will be implemented to ensure a diagnosis is received for each medication ordered on every new admission. A tracking log will also be implemented to ensure pharmacy recommendations to the physician are received, returned and noted by the nursing staff. Nurses will be in-serviced on the checklist, log and ensuring all recommendations by the pharmacist are completed. Random weekly audits will be completed for one month then monthly for three months by the DON or designee to ensure prescribed medications have appropriate diagnosis as well as ensuring pharmacy recommendations are completed.	9-16-16

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F 428	Continued From page 9 on 8/4/16 at 9:53 AM confirmed there was no documentation to show the pharmacist recommendation was addressed by the physician. Interview with RN #1 on 8/4/16 at 9:05 AM revealed that the facility received a verbal order on that morning at 9:00 AM responding to a written order originally dated 4/28/16 clarifying the diagnosis for the use of gabapentin. 2. Review of the 5/26/16 admission MDS assessment showed resident #36 had diagnoses that included diabetes and depression. Review of the pharmacist recommendation form dated 6/27/16 showed the resident was on insulin and the pharmacist noted there was no HgbA1c (blood test to measure what percentage of hemoglobin - a protein in red blood cells that carries oxygen - is coated with sugar) on file in the chart and had requested an order for the test. Continued review did not show the physician had addressed the pharmacist recommendation. Further review of the medical record showed the pharmacist noted three times in the chart ("4/16", "7/16" and again on 7/27/16) a recommendation to reduce the dosage of the resident's Celexa (medication used to treat depression) from a maximum dosage of 40 mg (milligrams) to 30 mg and possible 20 mg. Continued review did not show the physician addressed the pharmacist recommendation. Review of subsequent orders did not show an order to reduce the medication dose. Interview with the DON on 8/4/16 at 9:53 AM confirmed there was no documentation to show the pharmacist recommendation was addressed by the physician. Interview with RN #1 on 8/4/16 at 9:00 AM confirmed there was no evidence to show the physician acted on pharmacist recommendations for the laboratory test.	F 428	4. Results of these audits will be reviewed at the Performance Improvement meeting monthly for three months or until the committee is able to determine the process in place is effective.	

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	535039	A. BUILDING _____ B. WING _____	C 08/04/2016

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F 428	Continued From page 10 3. Review of physician's orders revealed resident #24 was ordered diazepam (generic name for Valium) 10 mg every six hours. Further review of the medical record showed a pharmacy recommendation report dated 4/27/16 which read "Resident is on diazepam 10 mg q6h. We do not have a valid diagnosis for use of this in the chart. Could you please document diagnosis and risk vs. benefit of 40 mg/day of diazepam?" Review of the medical record showed no evidence the physician acted upon the report. Additional review showed another pharmacy recommendation dated 7/27/16 which read "...We do not have a valid diagnosis for use of Valium in the chart and the dose is rather high. Could you please document diagnosis and risk vs. benefit of 40 mg/day of diazepam?" During an interview on 8/4/16 at 9 AM, RN #1 stated the physician had not acted upon the pharmacy report prior to 8/4/16. She stated the facility obtained an order from the physician that day which indicated the diagnosis for the diazepam was muscle spasms.	F 428		
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,	F 441	F441 –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. 1. Infection Control practices for Resident #27 and all other residents receiving perineal care have been corrected. The correct PPE for laundry staff has been purchased.	9-16-16

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F 441	Continued From page 11 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review the facility failed to ensure infection prevention practices were followed during observation of perineal care for 1 of 6 sample residents (#27) observed for that care. In addition, the facility failed to ensure appropriate personal protective equipment (PPE) was available to laundry staff for infection prevention and control in 1 of 1 laundry room. The findings were: 1. Observation on 8/2/16 at 9:35 AM showed CNA	F 441	2. Random observations were completed of all nursing staff to ensure they were following policy on proper use of gloves when providing perineal care. 3. All nursing staff will be educated by the Staff Development Coordinator regarding the proper use of gloves when providing perineal care. Laundry staff will also be educated on the use of proper PPE when handling soiled linens. DON and/or Staff Development Coordinator will conduct random audits weekly for one month then monthly thereafter for three months of all nursing staff to ensure they are following the policy regarding proper use of gloves during perineal care. Audits will also be conducted weekly for one month and monthly thereafter for three months of the laundry area to ensure staff are wearing proper PPE while handling soiled linens. 4. Results of these audits will be reviewed at the Performance Improvement meeting monthly for three months or until the committee is able to determine the process in place is effective.	

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F 441	Continued From page 12 #1 and RN #1 assisted resident #27 off of the bed pan. The following concerns were identified: a. CNA #1 provided perineal care to the resident and without removing the soiled gloves, the CNA obtained clean clothing for the resident. At that time, the CNA touched the resident's clean clothes, closet door, and wheelchair with the soiled gloves. b. After providing perineal care the resident thought his/her pants were "wet" and wanted them changed. CNA #1 checked the resident's pants, confirmed they were wet, and removed them. The CNA handed the "wet" pants to the RN #1, who grabbed them with an ungloved hand, exited the room, and walked down the hallway with them. c. Interview with the infection control nurse on 8/3/16 at 5:15 PM revealed the CNA should have changed gloves prior to touching anything in the room to prevent cross contamination and the RN should have wore gloves before handling the "wet" clothing. Further, it was revealed the staff should bag all soiled linen before exiting a room and carrying it down the hallway. d. Review of the policy titled "Using Gloves" last revised 5/21/04 showed "...Disposable (single-use) gloves must be replaced as soon as practical when contaminated...When to use gloves:...When handling potentially contaminated items..." 2. Observation of the dirty linen area of the laundry room on 8/4/15 at 9:45 AM showed the staff used a cloth-type lab coat for handling contaminated linen items. When placed under running water in the sink, the cloth soaked up the water and wet the inside of the coat. Interview with the laundry aide #1 on 8/4/16 at 9:45 AM revealed the cloth lab coat was the PPE that was	F 441		

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F 441	Continued From page 13 used when handling blood or body fluids. Further, it was confirmed that when contact with blood or body fluids was made, it could soak through and potentially contaminate employees.	F 441	F502 –Administration The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to ensure ordered laboratory tests were performed for 1 of 14 sample residents (#66) who had orders for laboratory tests. The findings were: 1. Review of physician orders for resident #66 showed an order dated 5/9/16 for the resident to have an amylase and lipase test performed. Review of the resident's medical record showed no evidence the amylase and lipase tests were obtained. Interview with the DON on 8/4/16 at 9:45 AM revealed the laboratory tests were not completed.	F 502	1. MD has been contacted regarding obtaining the amylase and lipase test for Resident #66. 2. A 100% audit by the DON will be completed of all labs ordered in the last 30 days to ensure they have been completed. 3. Nurses will utilize a lab tracking log which will be completed each time a lab is ordered. The DON or designee will conduct weekly audits for one month then monthly thereafter of the lab tracking log and physician orders to ensure labs are being completed as ordered. DON will educate all nurses on utilizing the lab tracking log as well as the importance of following through with lab draws when ordered by a physician. 4. Results of these audits will be reviewed at the Performance Improvement meeting monthly for three months or until the committee is able to determine the process in place is effective.	9-16-16
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.	F 520		

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F 520	Continued From page 14 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 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 review of the CMS-2567, staff interview and medical record review, the facility failed to have an effective quality assessment and assurance program to correct identified deficiencies. The findings were: 1. Review of the CMS-2567 dated 7/23/15 showed F318 was cited during the previous survey related to restorative nursing services not being provided as needed. Medical record review showed restorative nursing services were not provided as needed to sample resident #36 in July 2016. Refer to F318 for details on this issue being cited again during the current survey. 2. During an interview on 8/4/16 at 9:30 AM the administrator and DON stated the facility had identified restorative nursing as a concern. They	F 520	F520- QAA Committee A facility must maintain a quality and assessment assurance committee consisting of the director of nursing services, a physician designated by the facility, and at least three other members of the facility staff. 1. The facility is now utilizing a quality monitoring tool to evaluate and address concerns regarding cited survey deficiencies to ensure effectiveness of implemented processes. 2. The Performance Improvement committee will use the QAPI process for identifying more facility specific concerns as well as survey identified concerns. 3. Performance Improvement committee will be in serviced at the next meeting on utilizing the QAPI process to identify concerns and the effectiveness of processes used to correct deficiencies/concerns. Monthly audits by the ED will be conducted for three months to ensure compliance. 4. Monthly Performance Improvement data will be examined to ensure cited deficiencies have been corrected as well as the effectiveness of the evaluation process.	9-16-16

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F 520	Continued From page 15 stated after last year's survey, restorative nursing was looked at in QA for awhile, and then was removed when it improved. They stated the facility had noticed restorative nursing was a problem again "early this year," but stated that restorative nursing was not being formally looked at in QA.	F 520		