STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535034	A. BUILDING _____ B. WING _____ SEP 06 2016 Healthcare Licensing	pp 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWARD HEIGHTS CARE CENTER	150 CARING WAY LANDER, WY 82520

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F 000	INITIAL COMMENTS A recertification survey was conducted at Westward Heights Care Center in Lander, Wyoming by the Office of Healthcare Licensing and Surveys on 8/8/16 through 8/11/16. The following common abbreviations are used throughout this document: CNA Certified Nurse Aide ADON Assistant Director of Nursing MAR Medication Administration Record MDS Minimum Data Set PRN abbreviation meaning "when necessary" (from the Latin "pro re nata") Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Natalie Corell — TITLE: Administrator — (X6) DATE: 9/2/16

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. 9/21/16 @ 11 AM POC accepted per telephone call with Robbalee Peterson, DON.

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F 156	Continued From page 1 items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State	F 156		

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F 156	Continued From page 2 ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the posting of State advocacy group contact information was accurate for 2 of 2 postings (100 hall, 200 hall). The findings were: Observation of the facility's posting of advocacy group contact information on 8/11/16 at 9:45 AM showed the telephone number and address for the State survey agency was incorrect. Further, the telephone number for the regional ombudsman was incorrect. Interview with the administrator on 8/11/16 at	F 156	F156 The postings displaying the incorrect phone number for the Wyoming Department of Health and the Regional Ombudsman was corrected on August 10. The Social Service Coordinator will maintain the accurate addresses and phone numbers on the signage to ensure that residents and family members have the correct numbers to contact pertinent State client advocacy groups. The Social Services Coordinator will check the numbers on a quarterly basis and correct the names, phone numbers and addresses if they have changed. The Social Services Coordinator will report the changes at the QAPI meeting.	9/23/16

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F 156	Continued From page 3 11:15 AM verified the postings were incorrect and needed to be updated.	F 156		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure resident privacy and	F 164	F164 The survey posting including the list of confidential resident names was corrected as soon as the surveyor notified the Administrator. The Administrator will ensure that the confidential name list is removed before adding the most recent survey reports to the publicly posted survey results. The People Development Coordinator will check the survey posting book after the Administrator has included the most recent survey and plan of correction to ensure the confidential name list has been removed from the survey results. The result of the check of the survey book will be reported at the next QAPI meeting.	9/23/16

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F 164	Continued From page 4 confidentiality of protected health information for 1 of 1 survey result postings reviewed. The findings were: Observation of the facility's posting of past survey results on 8/11/16 at 9:45 AM showed a confidential list of resident names and associated identifiers was included with the survey results. Interview on 8/11/16 at 11:15 AM with the administrator confirmed the resident list should not have been available with the survey results.	F 164		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, policy and procedure review, and medical record review, the facility failed to ensure an assessment of safe self-administration of medications was completed for 1 of 2 sample residents (#18) who self-administered medications. The findings were: 1. Review of the 8/5/16 admission MDS assessment showed resident #18 had diagnoses that included COPD (chronic obstructive pulmonary disease). Further review showed a BIMS (Brief Interview of Mental Status) score of 15/15, indicating the resident was cognitively intact. The following concerns were identified:	F 176	F176 **Corrective action to resident(s):** Physician order was obtained for self administration, resident was assessed for competency, self administration MAR was implemented, and resident was given a lock box to keep inhaler in for remainder of stay at facility. **How problem is identified for other residents and what corrective actions will be taken:** MDS or their designee will audit records to determine if current residents have self administration physician orders. Resident rooms have been searched for all medications. The facility protocol will be followed for all medications located and those ordered to be be kept at bedside. **Measures/systemic changes to prevent recurrence:** On 8/12/16 MDS developed a protocol for resident self administration of	9/23/16

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F 176	Continued From page 5 a. Observation on 8/8/16 at 4:17 PM showed an inhaler on the resident's bedside table. The resident was not in the room at that time. Observation on 8/10/16 at 3:30 PM showed an inhaler, labeled Proventil (albuterol), was on the resident's bedside table. Interview with the resident at that time revealed s/he used it for his/her COPD and s/he had another inhaler in his/her top drawer. b. Review of the "Admission/Re-admission Orders," dated 8/7/16, showed no evidence of a physician's order for an albuterol inhaler. c. Review of the medical record showed no evidence the resident had been assessed for safety related to self-administering medications. d. Interview with the ADON on 8/11/16 at 1:08 PM confirmed she saw an inhaler on the resident's table, and added the resident's nurse had been unaware the resident used an inhaler. She stated the facility was working on getting a physician's order for the inhaler to be kept at the resident's bedside; then the facility would pursue completing an assessment for self-administration of medications. 2. Review of the "Self-Administration of Medications" policy dated 12/2/15 showed, "...2. An order must be obtained from the resident's physician for self-administration of the specific medication(s) under consideration...The physician order of 'may keep at bedside' will be accepted as a self-administration order, and the same guidelines should be followed...5. The decision that a resident has the ability to continue to safely self-administer medication(s) shall be evaluated by the interdisciplinary team with the resident's quarterly and significant change assessments as they come due."	F 176	medications, including obtaining orders, completing an assessment, implementing a care plan, resident MARs, and individual lock boxes. Self administration will be re-assessed quarterly and with any significant change. If a resident is found to be unable to follow the protocol, medication will not be allowed to be self administered. Charge nurses have been educated on the new protocol. **Monitor permanent solution:** Random audits of resident records and random room searches will be completed over the next 60 days. Results of audits will be discussed at monthly QA meetings.	

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F 253	Continued From page 6	F 253		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 2 of 5 resident areas (100 hall, 200 hall) were in good repair. The findings were: 1. Observation on 8/10/16 at 11:47 AM showed the following concerns: a. In resident room #203, the inside bathroom door had horizontal gouges in the wood from the bottom of the door to 5 inches up, exposing rough, splintered wood. b. In resident room #205, the outside bathroom door had a wooden door knob bumper (block to protect surfaces from door knobs) with a rough and splintered gouge measuring 1 inch by 1 inch. c. In resident room #209, the upper right corner of the wooden frame around the air conditioning unit was lifting from the wall exposing a sharp pointed edge of the framing. The wall above the corner of the framing to the bottom of the window had areas of missing paint and holes in the drywall. d. In resident room #220, the inside bathroom door had multiple horizontal gouges measuring the width of the door to a height of 23 inches, exposing rough unfinished wood. e. In the bathroom between resident rooms #206 and #208, the wall above the toilet had	F 253	F253 The facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. The areas that were not in good repair have been corrected as follows: a) Room #203 bathroom door has been sanded and repaired so the scratches and splintered wood are in good repair. b) Room #205 - the wooden bumper has been sanded and the gouged wood has been filled so it does not have a rough splintered surface. c) Room #209 - the upper right corner of the frame around the air conditioning unit has been repaired. d) Room #220 bathroom door has been repaired and gouges have been filled. e) The bathroom in between #208 and #206 had gouges in the drywall that has been repaired so that there is a cleanable washable surface on the wall.	9/23/16

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F 253	Continued From page 7 gouges in the drywall the length of the toilet tank, creating an uncleanable surface. f. In resident room #208, the outside bathroom door had a hole approximately 3 feet above the floor, measuring 2 inches in diameter with rough jagged edges. g. In resident room #204, the outside bathroom door had a wooden door knob bumper with a rough and splintered gouge measuring 1.25 inch by 0.5 inch. h. In resident room #104, the outside bathroom door had a wooden door knob bumper with a rough and splintered gouge measuring 3 inches by 0.5 inch. i. In resident room #107, the outside bathroom door had a wooden door knob bumper with a gouge measuring 1.5 inch by 0.5 inch, exposing rough and splintered wood. j. In the bathroom of resident room #112, the grab bars on both sides of the toilet had grip tape that was peeling loose, creating an uncleanable surface. 2. Interview with the maintenance director on 8/11/16 at 9:10 AM verified the identified areas were in need of repair.	F 253	f) #208 bathroom door has a 2 inch hole that has been repaired. g) #204 door knob bumper on the bathroom door has been repaired so the splintered gouge is fixed. h) #104 the outside bathroom door gouge has been covered i) #107 wooden door knob bumper has been repaired and splintered wood is no longer present. j) #112 bathroom the grip tape was fixed so that there is a cleanable surface on the grab bars.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279	The maintenance and housekeeping supervisor will do monthly walkthroughs to look at the doors, bathrooms, residents rooms to ensure any identified holes are repaired, sanded, and any areas that have been damaged will be repaired to ensure a cleanable/washable surface. The areas identified for repair will be documented in the maintenance repair log and fixed immediately. The repairs to resident rooms will be reported quarterly at Safety Meetings by the Maintenance or Housekeeping Supervisor.	

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F 279	Continued From page 8 assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the care plan described details necessary to maintain the highest practicable physical well being for 1 of 12 sample residents (#48). The findings were: Review of admission/re-admission orders dated 7/12/16 showed resident #48 had a diagnosis of chronic obstructive pulmonary disease (COPD), a chronic lung disease that makes it hard to breathe. Review of the physician's orders showed "Oxygen per n/c [nasal cannula] to keep SpO2 [pulse oximetry oxygen saturation] 88-92%, not higher." Review of the care plan showed the resident had poor endurance due to shortness of breath related to COPD. Further review showed the approach for this problem was for staff to administer the resident's oxygen therapy as ordered, without describing the specific parameters to be followed. Interview on 8/11/16 at 11:11 AM with the ADON	F 279	F279 **Corrective action to resident(s):** Resident's care plan and care guide were updated on 8/12/16 to state specific oxygen orders. **How problem is identified for other residents and what corrective actions will be taken:** An audit of all residents with oxygen orders will be completed and care plans updated with any specific oxygen parameters. **Measures/systemic changes to prevent recurrence:** MDS/Care Plan Coordinators will ensure that any new residents with specific oxygen orders have this information communicated on the care plan and care guide. **Monitor permanent solution:** Random audits of oxygen orders and care plans will be completed over the next 60 days. Results of audits will be discussed at monthly QA meetings.	9/23/16

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F 279	Continued From page 9 revealed her expectation, in reviewing the order and care plan, was for the care plan to have detailed the parameters ordered to inform staff how to care for the resident.	F 279		
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 care was provided in accordance with the written plans of care for 2 of 14 sample residents (#27, #53). The findings were: 1. Review of the 8/4/16 quarterly MDS assessment showed resident #53 had diagnoses that included Parkinson's disease and muscle weakness. Further review showed the resident was always incontinent of urine, and required extensive assistance for transferring and toileting. Review of the resident's care plan showed to "Assist [resident] to bathroom every two hours". The following concerns were noted: a. Observation on 8/9/16 at 8:32 AM showed the resident being assisted out of the dining room to the library area in a wheelchair. Continued observation showed the resident remained in the library until 9:51 AM. At that time, CNA #1 wheeled the resident to his/her room where she and another unidentified CNA transferred the resident to the bed. The CNAs did	F 282	F282 **Correct Deficiency to Individual:** 1. Nursing staff will be in-serviced on the policy to assist to the toilet or provide incontinence care every 2 hours for resident #53. They will also be in-serviced on following care plans for residents who need assistance with elimination. 2. Medication errors will be written for the times that liquid morphine, morphine IR, and ibuprofen were given PRN and post pain assessment documentation was not present on resident #27. A Pain Performance Improvement Project was implemented in August of 2016, and education was given to licensed nurse staff on post pain assessment documentation.	9/23/16

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F 282	Continued From page 10 not offer to toilet the resident or check to see if s/he was incontinent. At 11:56 AM, CNA #2 entered the room and asked if the resident wanted to go to the dining room. The resident declined. The CNA did not offer to toilet the resident or check for incontinence. Continued observation at 1:20 PM (4 hours and 48 minutes from start of observation) revealed CNA #2 repositioned the resident in bed and proceeded to exit the room. At that time the surveyor asked the CNA to check the resident for incontinence. Further observation revealed the CNA removed the resident's urine-saturated disposable brief, provided peri-care, and placed a clean disposable brief on the resident. b. Interview with the ADON on 8/11/16 at 1:08 PM revealed her expectation was for the resident to be assisted with toileting or incontinence care "at least every two hours." She further revealed "5 hours [without being offered to toilet or checking for incontinence] is unacceptable." 2. Review of the 6/14/16 quarterly MDS assessment showed resident #27 had diagnoses that included rheumatoid arthritis, diabetes, and chronic obstructive pulmonary disease. This review also showed the resident had almost constant pain that limited daily activities, made it hard to sleep, and was rated 10 for intensity (pain level rate on a scale of 0 to 10 with 10 being the worst). Review of the care plan, revised 6/14/16 showed one of the interventions for pain was to assess effectiveness of medication and other interventions. Review of the July 2016 physician orders showed the pharmacological approach for pain management for this resident included: a Fentanyl transdermal patch 50 micrograms every 72 hours, morphine liquid 20 milligrams (mg)	F 282	**How problem is identified for other residents and what corrective actions will be taken:** 1. An audit will be completed to identify all residents who require assistance with elimination, and ensure they have a proper care plan. 2. An audit of residents taking PRN pain medication will be completed by the DON or their designee. Medication errors will be written for any time that PRN pain medication is given without post pain assessment documentation. Verbal coaching to licensed nurses will be provided on medication errors. **Measures/systemic changes to prevent recurrence:** 1. Nursing staff will be in-serviced on following the interventions as listed on the care plan. 2. In the future, pain assessment documentation training will occur during charge nurse training (for all new licensed nurses). All current nurses will be in-serviced in September 2016 on the Pain Operating Standard and	

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F 282	Continued From page 11 every 2 hours PRN, , morphine IR (immediate release) 15 mg every 6 hours PRN, Tylenol 500 mg every 4 hours PRN and ibuprofen 400 mg every 6 hours PRN. The following concerns were noted: a. Review of the 2016 July and August pain flow sheet, MARs, and nursing notes showed no assessment for effectiveness was completed after the resident received morphine liquid 20 mg two times on 7/6/16, 7/7/16, and 7/8/16. b. Review of the 2016 July pain flow sheet, MARs, and nursing notes showed no assessment for effectiveness was completed after the resident received morphine IR 15 mg on 7/2/16, 7/3/16, 7/4/16 two times, 7/8/16, 7/10/16, 7/14/16, 7/15/16 two times, 7/16/16 two times, and 7/17/16 two times. c. Review of the 2016 August pain flow sheet, MARs, and nursing notes showed no assessment for effectiveness was completed after the resident received morphine IR 15 mg 6 times. d. Review of the 2016 August pain flow sheet, MARS, and nursing notes showed no assessment for effectiveness was completed after ibuprofen was administered on 8/1/16, 8/3/16, 8/7/16 and 8/8/16. e. Interview with the ADON on 8/11/16 at 8:30 AM confirmed the assessments had not been completed as directed by the care plan.	F 282	requirements for post pain assessment documentation. Nurses will be educated on documenting all post pain assessments on resident-specific pain flow sheets, located in the MAR **Monitor Permanent Solution:** 1. The SDC/ICN or their designee will conduct random weekly audits for 60 days to assure proper care is provided. Any issues identified will be corrected immediately. Results of observations for following the care plan will be reviewed by the Interdisciplinary Team (IDT) for compliance and direct any further corrective action needed. Results of audits will be discussed at monthly QA meetings. 2. The DON or their designee will complete random chart	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309	audits for the next 60 days to ensure that post PRN pain medication assessments are completed. Results of these audits will be presented at the monthly QAPI meeting.	

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F 309	Continued From page 12 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff and resident interview and medical record review the facility failed to ensure effective pain management for 2 of 9 sample resident who required pain management (#27, #56). The findings were: 1. Review of the 6/14/16 quarterly MDS assessment showed resident #27 had diagnoses that included rheumatoid arthritis, diabetes, and chronic obstructive pulmonary disease. This review also showed the resident had almost constant pain that limited daily activities, made it hard to sleep, and was rated 10 for intensity (pain level rate on a scale of 0 to 10 with 10 being the worst). Review of the care plan, revised 6/14/16 showed one of the interventions for pain was to assess effectiveness of medication and other interventions. Review of the July 2016 physician orders showed the pharmacological approach for pain management for this resident included: a Fentanyl transdermal patch 50 micrograms every 72 hours, morphine liquid 20 milligrams (mg) every 2 hours PRN, morphine IR (immediate release) 15 mg every 6 hours PRN, Tylenol 500 mg every 4 hours PRN and Ibuprofen 400 mg every 6 hours PRN. The following concerns were noted: a. During an interview on 8/9/16 at 2:45 PM, the resident stated s/he was in pain "all the time." S/he further stated the pain in his/her neck and shoulders had increased in the past 2 months and sometimes the medication "helped	F 309	F309 **Corrective action to resident(s):** #27: Medication errors will be written for the times that liquid morphine, morphine IR, and ibuprofen were given PRN and post pain assessment documentation was not present. A Pain Performance Improvement Project was implemented in August of 2016, and education was given to licensed nurse staff on post pain assessment documentation. An investigation into adminstration of resident's liquid morphine showed that this medication was being given per physician orders when morphine IR was not available for a short time from the pharmacy. #56: Medication errors will be written for the times that resident was given Tylenol and Hydrocodone/ Acetaminophen and post pain assessment documentation or documentation in the MAR were not present. Resident no longer resides at facility. **How problem is identified for other residents and what corrective actions will be taken:** An audit of residents taking PRN pain medication will be completed by the	9/23/16

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F 309	Continued From page 13 and sometimes it didn't." b. Review of the 2016 July and August pain flow sheet, MARs, and nursing notes showed no assessment for effectiveness was completed after the resident received morphine liquid 20 mg two times on 7/6/16, 7/7/16, and 7/8/16. Further review revealed this medication was not administered in August 2016. During an interview on 8/11/16 at 8:30 AM, the ADON stated she was unsure of why the nurses stopped administering this pain medication. c. Review of the 2016 July pain flow sheet, MARs, and nursing notes showed no assessment for effectiveness was completed after the resident received morphine IR 15 mg on 7/2/16, 7/3/16, 7/4/16 two times, 7/8/16, 7/10/16, 7/14/16, 7/15/16 two times, 7/16/16 two times, and 7/17/16 two times. d. Review of the 2016 August pain flow sheet, MARs and nursing notes showed no assessment for effectiveness was completed after the resident received morphine IR 15 mg 6 times. e. Review of the 2016 August pain flow sheet, MARS and nursing notes showed no assessment for effectiveness was completed after ibuprofen was administered on 8/1/16. 8/3/16, 8/7/16 and 8/8/16. f. Interview with the ADON on 8/11/16 at 8:30 AM revealed the incomplete and missing assessments made it difficult to determine the effectiveness of the pain management program for this resident. 2. Review of the the medical record for resident #56 showed the resident was admitted to the facility on 1/19/15 and discharged to another facility on 5/9/16. Review of the 5/9/16 discharge MDS assessment showed the resident had pain.	F 309	DON or their designee. Medication errors will be written for any time that PRN pain medication is given without post pain assessment documentation or documentation is not present in the MAR. Verbal coaching to licensed nurses will be provided on medication errors. **Measures/systemic changes to prevent recurrence:** In the future, pain assessment documentation training will occur during charge nurse training (for all new licensed nurses). All current nurses will be in-serviced in September 2016 on the Pain Operating Standard and requirements for post pain assessment documentation. Nurses will be educated on documenting all post pain assessments on resident-specific pain flow sheets, located in the MAR. **Monitor permanent solution:** The DON or their designee will complete random chart audits for the next 60 days to ensure that post PRN pain medication assessments are completed. Results of these audits will be presented at the monthly QAPI meeting.	

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F 309	Continued From page 14 Review of the care plan, updated 3/15/16, showed interventions for pain included monitoring for worsening of pain symptoms, administering pain medications, and assisting with diversional activities. Review of the 3/6/16 nurse's notes showed the resident cried due to severe pain. Review of the March 2016 physician's orders and notes showed the pharmacological pain management for the resident consisted of scheduled doses of Tylenol 650 mg twice daily, hydrocodone-acetominophen 5/325 mg PRN twice daily, and Tylenol 650 mg PRN twice daily. The following concerns were identified: a. Review of the April and May 2016 pain management documentation in the nurse's notes, MAR, and pain flow sheet revealed assessments for effectiveness of medication and non-pharmacological interventions were not completed after hydrocodone-acetominophen was administered for pain on 4/10/16, 4/20/16, 5/7/16 and 5/9/16. b. Review of the April and May 2016 pain management documentation in the nurse's notes, MAR, and pain flow sheet revealed assessments for effectiveness of medication and non-pharmacological interventions were not completed after Tylenol was administered for pain on 4/1/16, 4/25/16 and 5/4/16. c. Review of the April 2016 pain flow sheet showed a pain assessment was completed before and after PRN Tylenol was administered on 4/6/16 and 4/8/16. However, according to the MAR the medication was not administered on those days. d. Review of the policy and procedure titled, "Pain Management Standard", revised 12/3/15, showed standards that included: Evaluate effectiveness of PRN pain medication. If reassessment findings indicate pain is not	F 309		

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F 309	Continued From page 15 adequately controlled, revise the pain management regimen and care plan as indicated. e. Interview with the MDS coordinator 8/11/16 at 9:30 AM verified the facility's pain management program had not been implemented according to the policy and procedure.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure incontinent care was provided in a timely manner for 1 of 6 sample residents (#53) who required assistance with urinary incontinent care. The findings were: 1. Review of the 8/4/16 quarterly MDS assessment showed resident #53 had diagnoses that included Parkinson's disease and muscle weakness. Further review showed the resident was always incontinent of urine, and required extensive assistance for transferring and toileting. Review of the resident's care plan showed to "Assist [resident] to bathroom every two hours".	F 315	F315 **Correct Deficiency to Individual:** Resident #53 receives assist with toileting/incontinence care per care plan. Staff will be educated on the need to provide assist with toileting for residents who need assistance with elimination. **How problem is identified for other residents and what corrective actions will be taken:** An audit will be completed to identify all residents who require assistance with elimination, to ensure proper care is being provided and care plan is in place. **Measures/systemic changes to prevent recurrence:** Nursing staff will be educated on providing care for residents who need assistance with elimination. Staff is provided peri care competency education on a yearly basis, on or near their anniversary month.	9/23/16

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F 315	Continued From page 16 The following concerns were noted: a. Observation on 8/9/16 at 8:32 AM showed the resident being assisted out of the dining room to the library area in a wheelchair. Continued observation showed the resident remained in the library until 9:51 AM. At that time, CNA #1 wheeled the resident to his/her room where she and another unidentified CNA transferred the resident to the bed. The CNAs did not offer to toilet the resident or check to see if s/he was incontinent. At 11:56 AM, CNA #2 entered the room and asked if the resident wanted to go to the dining room. The resident declined. The CNA did not offer to toilet the resident or check for incontinence. Continued observation at 1:20 PM (4 hours and 48 minutes from start of observation) revealed CNA #2 repositioned the resident in bed and proceeded to exit the room. At that time the surveyor asked the CNA to check the resident for incontinence. Further observation revealed the CNA removed the resident's urine-saturated disposable brief, provided peri-care, and placed a clean disposable brief on the resident. b. Interview with the ADON on 8/11/16 at 1:08 PM revealed her expectation was for the resident to be assisted with toileting or incontinence care "at least every two hours." She further revealed "5 hours [without being offered to toilet or checked for incontinence] is unacceptable."	F 315	**Monitor Permanent Solution:** The SDC/ICN or their designee will conduct random resident audits for the next 60 days to assure proper care is provided. Any issues identified will be corrected immediately. The results of these audits will be discussed at monthly QA meetings.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections;	F 328	F328 **Corrective action to resident(s):** Resident's care plan and care guide were updated on 8/12/16 to state specific oxygen orders.	9/23/16

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F 328	Continued From page 17 Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure oxygen therapy was appropriately monitored for 1 of 8 sample residents (#48) who needed supplemental oxygen. The findings were: Review of admission/re-admission orders dated 7/12/16 showed resident #48 had a diagnosis of chronic obstructive pulmonary disease (COPD), a chronic lung disease that makes it hard to breathe. The orders showed "Oxygen per n/c [nasal cannula] to keep SpO2 [pulse oximetry oxygen saturation] 88-92%, not higher." The following concerns were identified: a. Review of the resident's vital signs record showed SpO2 levels from July and August exceeded 92% on 23 occasions. The SpO2 levels ranged from 93% to 99%. b. Review of interdisciplinary progress notes showed the resident was admitted due to COPD exacerbation. However, other than on 7/14/16 at 10:25 AM, the progress notes failed to provide information to show what was done when the SpO2 levels were elevated. c. Review of the care plan dated 7/12/16 showed the resident had poor endurance due to shortness of breath related to his/her COPD diagnosis. Review of the approach to care	F 328	**How problem is identified for other residents and what corrective actions will be taken:** An audit of all residents with COPD will be completed by the MDS Coordinator or their designee to ensure compliance with oxygen parameters. **Measures/systemic changes to prevent recurrence:** Staff will be educated on specific oxygen orders through the care plan, care guide on residents with COPD or orders for oxygen with specific paraments. **Monitor permanent solution:** Random audits will be completed by the MDS Coordinator or their designee with nursing staff related to specific oxygen orders for the next 60 days. Results of the audits will be reported at monthly QAPI meeting by MDS Coordinator.	

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F 328	Continued From page 18 showed directions to administer resident's oxygen therapy as ordered. However, the instruction to keep his/her oxygen saturation between 88-92% was not included in the care plan. d. Interview on 8/10/16 at 3:15 PM with CNA #3 revealed he was not aware of specific O2 saturation levels that needed to be reported to the nurse; and he had no knowledge of acceptable parameters for this resident. e. Interview on 8/11/16 at 11:11 AM with the ADON revealed her expectation, in reviewing the order and recorded vital signs, was that a nurse should have monitored vital signs and titrated oxygen to bring the resident's SpO2 into ordered range.	F 328		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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	F 329	F329 **Corrective action to resident(s):** A gradual dose reduction has been requested for resident #39's Lexapro. **How problem is identified for other residents and what corrective actions will be taken:** The psychotropics committee (Administrator, ADON, SDC/ICN, MDS Coordinator, Social Services, and consultant pharmacist [on a monthly basis]) will review all residents in the facility according to their quarterly care plan schedule to ensure that duration of drug use guidelines for gradual dose reduction of drug classes have been followed.	9/23/16

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F 329	Continued From page 19 drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review, and resident and staff interview, the facility failed to ensure medication regimens were free of unnecessary drugs for 1 of 9 sample residents (#39) who used psychotropic medications. The findings were: 1. Review of the interdisciplinary progress note dated 10/29/14 showed resident #39 received an order for Lexapro 5 mg PO [by month] daily. Review of the 4/1/15 physician order showed an increase in Lexapro to 10 mg PO daily related to the resident sleeping too much and a depression score increase. Review of the 3/8/16 and 6/7/16 quarterly MDS assessments showed the mood severity scores were noted as a 2/27 indicating minimal depression (0-4). The resident noted trouble falling asleep/staying asleep or sleeping too much half or more than half of the days. However, the resident did not indicate having little interest or pleasure in doing things, feeling down, depressed or hopeless, feeling tired or having little energy, having poor appetite or overeating, feeling bad about self or feeling of having let self or family down, trouble concentrating on things, moving or speaking so slowly that others people could have noticed, or thoughts of being better off dead or hurting self in some way. Review of the "Behavior/Intervention" monthly flow records for May, June and July 2016 revealed no episodes of negative statements or mood changes noted, and only 2 episodes in May of self-isolation/sleeping a	F 329	**Measures/systemic changes to prevent recurrence:** The psychotropics team will request gradual dose reductions for each individual psychoactive medication, according to drug class guidelines. The psychoactive medication review will be utilized during these meetings. Night shift nurses have been assigned to re-fax doctors weekly when gradual dose reduction papers have not been received timely. **Monitor permanent solution:** The DON, ADON or their designee will complete random chart audits for the next 60 days to ensure that GDRs have been requested on residents with psychoactive medications. Results of these audits will be presented at the monthly QAPI meeting.	

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F 329	Continued From page 20 lot, with interventions of redirection and giving food and fluids. The following concerns were identified: a. Review of the Request for Psychopharmacological Medication Change, request dated 9/25/15 showed the request was declined by the physician, signature dated 11/20/15 and the line item "DO NOT attempt to taper the dose of this drug. In my opinion, and/or by diagnosis, to do so is clinical contraindicated..." was checked. b. Review of the 3/8/16 and 6/7/16 psychoactive medication reviews showed the resident remained on Lexapro 10 mg PO daily. These reviews showed checkmarks to confirm that "A) Drug is used for specific acceptable Dx [diagnosis] and other causes of distress have been considered and ruled out. B) Resident's functional status is maintained or improved by use of drug ...C) Duration of drug use guidelines for GDR [gradual dose reduction] for the drug class have been followed ...D) Use of drug is equal or less than total daily dose unless higher dose is necessary for maintenance or improvement in resident's functional status as evidenced by response or clinical record. E) ADRs/Side Effects are absent." c. Interview with the resident on 8/9/16 at 9:58 AM revealed the resident was talkative and appeared happy. The resident explained his/her daily routine which included having meals and activities in his/her room. The resident had a computer which s/he enjoyed playing games on. The resident expressed satisfaction with his/her situation and also remarked on having good family support. d. Interview with administrator on 8/11/16 at 1:45 PM confirmed there had been no attempt to reduce the resident's medication Lexapro.	F 329		

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F 329	Continued From page 21 Further, the administrator explained the resident was ordered the Lexapro because s/he used to stay in bed all day.	F 329		9/23/16
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure equipment in 1 of 1 kitchens was sanitary. The findings were: Observation on 8/8/16 at 4 PM and 8/10/16 at 11:08 AM showed the following equipment was in need of cleaning/replacement: a. Two ceiling vents in the kitchen located above preparation areas were noted to have an accumulation of dust and grease on and around the vents. b. The cutting board of the steam table unit was stained and scored from use. c. The plastic water dispenser used in the lobby area for residents, visitors and staff had fissures and cracks in the plastic which did not allow for thorough cleaning. d. Four red plastic plate covers used for room trays were in poor condition with cuts and scrapes	F 371	F371 The facility will ensure that food is stored, prepared, and distributed and served in sanitary conditions. The areas identified in the survey have been corrected with the following actions: a. The ceiling vents in the kitchen were cleaned on 9/10/16 and they have been added to a semi-monthly cleaning schedule. b. The cutting board has been cleaned and a new one ordered to replace that cutting board. c. The plastic water dispenser in the lobby area was removed from service and a new dispenser was ordered. d. The identified plastic plate covers that needed replaced were thrown away and new plate covers were ordered. e. The plastic measuring cups were thrown away and glass measuring cups were ordered.	

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F 371	Continued From page 22 in the plastic on the interior and exterior of the covers. e. Seven plastic measuring cups stored on the clean equipment shelves were noted to be damaged with fissures and cracks in the surfaces. Interview with the dietary manager on 8/10/16 at 1 PM verified she had not done an inventory for the equipment recently and items that were in poor condition would be replaced. She also verified the vents were in need of cleaning.	F 371	The Dietary Manager or designee will do a monthly check of the condition of plastic kitchen ware each month. Items that need replaced will be discarded and new items ordered. The Dietary Manager will report the vent cleaning on a quarterly basis to the Safety Committee.	
F 387 SS=D	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 1 of 12 sample residents (#39) were seen by a physician at the frequency required. The findings were: Review of the admission face sheet showed resident #39 was re-admitted to the facility on 10/1/14. The physician progress notes showed the resident had diagnoses including cerebrovascular disease. According to the notes, the resident was seen by the physician on	F 387	F387 **Corrective action to resident(s):** Resident #39 did not have any adverse effects from not having a physician visit within the allowed time frame. Records from past physician visits have been requested. **How problem is identified for other residents and what corrective actions will be taken:** The Health Information Manager will audit all resident charts to ensure that 60 day physician visits have been completed, and that records of past visits are available in resident charts. **Measures/systemic changes to prevent recurrence:** The Health Information Manager will monitor 30 and 60 day visits on all residents, and will contact physicians	9/23/16

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F 387	Continued From page 23 12/11/15, 4/26/16, and 7/27/16. The time between these visits extended past the required 70 day time frame. Interview with the ADON on 8/11/16 at 1:10 PM verified documentation of additional physician visits could not be located.	F 387	the week before these visits are due, to make arrangements for residents to be seen at the facility. If a physician has not come to the facility within 60 days, an appointment will be made for the resident to be seen at the physician's office and the facility will provide transportation to the appointment before 70 days have elapsed. The HIM will contact each provider within 72 hours of their rounds at facility, to request records from resident visits. **Monitor permanent solution:** The HIM or designee will complete random chart audits over the next 60 days to ensure that physician visits have been completed or are scheduled, and that current records from physician visits are present. Results will be reported at monthly QAPI meetings by the HIM or designee.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431	F431 **Corrective action to resident(s):** Medication errors will be written for the times that liquid morphine, morphine IR, and Ativan were given PRN and documentation was not present on both the Controlled Substance Record and the Medication	9/23/16

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F 431	Continued From page 24 be readily detected. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of medical records, controlled substance records, medication administration records and policies and procedures, the facility failed to develop a system for identifying discrepancies in administration and documentation of medications for 1 of 1 sample resident (#27) who received daily doses of PRN controlled substance medications. The findings were: Review of the medical record for resident #27 showed s/he received morphine liquid 20 milligrams (mg) every 2 hours PRN and morphine IR (immediate release) 15 mg every 6 hours PRN for pain. Further review showed the resident also received Ativan 2 mg every 6 hours PRN for anxiety. On 8/11/16 at 8:30 AM the resident's individual controlled substance records and MARS were reviewed by the ADON with the surveyor. The following concerns were identified: a. The individual controlled substance record for morphine liquid 20 mg showed the medication was administered on 7/14/16. According to the MAR the resident did not receive the medication that day. b. The individual controlled substance records for Morphine IR 15 mg showed this medication was administered in July 2016 on 7/18, 7/19, 7/20, 7/23, 7/25, and 7/28. According to the documentation on the July 2016 MAR the resident did not receive the medication as documented on the controlled substance records for those dates.	F 431	Administration Record (MAR) for resident #27. A Pain Performance Improvement Project was implemented in August of 2016, and education was given to licensed nurse staff on post pain assessment documentation. **How problem is identified for other residents and what corrective actions will be taken:** An audit of residents taking PRN pain medication will be completed by the DON, ADON or their designee. Medication errors will be written for any time that PRN pain medication is given and documentation is not present in the MAR. Verbal coaching to licensed nurses will be provided on medication errors. **Measures/systemic changes to prevent recurrence:** In the future, pain assessment documentation training will occur during charge nurse training (for all new licensed nurses). All current nurses will be in-serviced in September 2016 on the Pain Operating Standard and requirements for pain assessment documentation. Nurses will be educated on documenting all	

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F 431	Continued From page 25 c. The 8/4/16 to 8/10/16 individual controlled substance record for Ativan 2 mg showed 3 doses of this medication were administered on 8/4/16, 4 doses on 8/5/16, 3 doses on 8/7/16, and 4 doses on 8/8/16. Review of the August 2016 MAR revealed fewer doses were administered on each of the four days resulting in 5 discrepancies. d. Interview with the ADON on 8/11/16 at 9 AM revealed she was not aware of the discrepancies. She further stated these types of discrepancies were categorized as medication errors, and the above discrepancies had not been identified in the facility's system for identifying, reporting, and tracking medication errors. e. Interview with the MDS coordinator on 8/11/16 at 9:30 AM, revealed she completed a review of the August 2016 medication administration records after the surveyor and ADON completed a review of the July records. She stated she was unable to reconcile the morphine IR administrations on the controlled substance records with the administered doses on the MARs due to inconsistent and missing documentation. f. Review of the policy and procedure for "Controlled Substances", dated July 2009, showed, "The DON or (their designee) shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsible parties."	F 431	pain assessments on resident-specific pain flow sheets, located in the MAR. A PRN medication flow sheet was implemented on all residents starting 8-19-16, to be used for documentation of all PRN medications that are not used for pain, in addition to documentation on the MAR. **Monitor permanent solution:** The facility's consultant pharmacist will complete monthly audits on narcotic documentation and reconciliation. The DON or their designee will complete random chart audits for the next 60 days to ensure that all documentation is present on narcotics administered to residents PRN. Results of these audits will be presented at the monthly QAPI meeting.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;	F 514	F514 **Corrective action to resident(s):** Fall risk assessments have been updated on residents #39 and #48.	9/23/16

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F 514	Continued From page 26 accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to accurately assess and document resident fall risk for 2 of 14 sample residents (#39 and #48). The findings were: 1. Review of fall risk assessment dated 7/13/16 for resident #48 revealed a total score recorded as "9", when the calculated score equaled "11". Review of the fall risk assessment dated 7/15/16 revealed a total score recorded as "10", when the calculated score equaled "11". The following concerns were identified regarding additional inaccuracies: a. Review of the 7/7/16 history and physical showed "family states [resident] has been having some increased confusion over the last week to the point today that [the resident's] daughter showed up at [the resident's] house" and found the resident on the couch... things were knocked over in the house, "apparently had had some falls". Review of the fall risk assessment instructions showed a history of 1-2 falls would be scored as "2", and 3 or more falls would be scored as "4". However, review of the completed fall risk assessments showed a "0" was entered under the section referring to history of falls on	F 514	**How problem is identified for other residents and what corrective actions will be taken:** Resident fall risk assessments will be audited per care plan schedule and corrected if any errors are found. **Measures/systemic changes to prevent recurrence:** Education will be given to nursing staff on completion of fall risk assessments. **Monitor permanent solution:** Random audits of resident fall risk assessments will be completed by the MDS Coordinator or their designee over the next 60 days. Results of audits will be discussed at monthly QA meetings.	

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F 514	Continued From page 27 assessments dated 7/12/16, 7/13/16, 7/14/16 and 7/15/16. b. Review of the medical record showed the resident was 92 years of age. Review of the fall risk assessment instructions showed a resident over the age of 85 should receive an additional "2" to their fall risk score. This section was left blank for assessment dates 7/12/16 and 7/14/16. 2. Review of fall risk assessment dated 6/7/16 for resident #39 revealed the total score was erroneously recorded as "8"; when the accurate total score equaled "10". According to the risk assessment scoring scale a score of 10 or higher is considered a high risk for falls. 3. Interview on 8/11/16 at 11:11 AM with the ADON verified the fall risk assessments for these residents had inaccurate totals and did not reflect actual fall risk.	F 514		