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	535013	A. BUILDING _____ B. WING _____	C 09/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE REHABILITATION AND WELLNESS	3128 BOXELDER DRIVE CHEYENNE, WY 82001

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 9/6/16 through 9/9/16. Complaints investigated during the course of this survey were complaint intakes WY000002239, WY000002244, WY000002254, WY000002270, and WY000002271. 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 LPN: Licensed Practical Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	Preparation and execution of the 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 153 SS=B	483.10(b)(2) RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	F 153	F153 Right to access/ Purchase copies of Records 1. **Corrective Action** Medicare and Medicaid benefit application information was posted on or before 10/05/2016 by the Executive Director or Designee. 2. **ID of Others**	10/05/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Direction — (X5) DATE: Updated on 10/14/2016, Original Submission 10/03/2016

Spoke with Lea Lowe Administrator on 10/20/16 at 1:10pm. POC Accepted.

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F 153	Continued From page 1 facility failed to ensure Medicare and Medicaid benefit application information was prominently displayed. The findings were: Observation on 9/9/16 at 12:20 PM revealed no evidence the facility had displayed Medicare and Medicaid benefit application information. Interview with the administrator at that time revealed the facility provided that information in writing upon admission to residents and the Power of Attorney. However, she confirmed the facility failed to prominently display that information in the facility.	F 153	The Executive Director completed a visual audit of the facility postings with regard to Medicare and Medicaid benefit application information and found that the postings were not specific to how to apply. 3. <u>Systemic Change</u> The Executive Director or designee will randomly inspect to ensure the Medicare and Medicaid benefit application information is posted. 4. <u>Monitoring</u> The Executive Director or designee will report results of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as determined by the committee.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to promote the dignity of residents during three random observations. The findings were: 1. Continuous observation on 9/6/16 beginning at 12:24 PM showed resident #37 was seated at a dining room table with two other residents who had been served a meal. Interview with resident #37 at 12:27 PM revealed the resident had milk, but s/he was unsure why s/he had not received any other food. Observation at 12:33 PM showed one of the resident's tablemates had finished eating and pushed his/her plate away. Two staff	F 241	F241 Dignity and Respect of Individuality 1. <u>Corrective Action</u> Resident #37 was provided a meal. Education of the staff was provided on September	10/05/2016

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F 241	Continued From page 2 members observed the meal and did not identify the resident did not have a meal until 12:36 PM, 12 minutes later. 2. Observation on 9/6/16 at 11:15AM showed the podiatrist performed exams and treatments on three residents in the dining area, while other residents were engaged in activities. 3. Interview with the DON on 9/9/16 at 11:43 AM revealed that personal care performed in the dining area in front of other residents and resident not getting served at the same time as tablemates could make the resident's feel undignified.	F 241	14, 2016 regarding serving meals timely and serving table mates together. The podiatrist was talked to on 9/6/16 regarding performing exams and treatments in common areas (dining room) and was shown a private area to perform exams and treatments. 2. <u>ID of Others</u> Residents who reside in the Center have the potential to be affected. 3. <u>Systemic Changes</u> The podiatrist will check in with social services each time in the facility. Social services will give the podiatrist their list of residents to see and will be escorted to the area the resident exam and treatments are to be performed. Education of staff with regards to meal service and podiatry visit process was completed on or before 10/05/2016 by the DNS or designee.	
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and review of the resident council minutes the facility failed to act upon the grievances of residents brought to staff's attention during resident council meetings for 3 of 3 months reviewed (June, July, August). The findings were: 1. Interview with the resident group on 9/7/16 at 10 AM revealed that 9 residents agreed that grievances brought forth during monthly resident	F 244		

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F 244	Continued From page 3 council meetings were not responded to or resolved. 2. Review of resident council meeting minutes dated 6/28/16 showed resident concerns included call light response time, room temperatures, housekeeping services, laundry services, missing resident clothing, missing garbage bin, night time nursing services and requests for small plastic bags for resident use. Further review showed there was no evidence the facility responded to the grievances or communicated resolution to the resident council. 3. Review of resident council meeting minutes dated 7/26/16 showed resident concerns included laundry services, missing clothes items, dietary services, meal service disruptions, missing personal items, noisy phones at nurses station, request for more activities, and request for birthday recognition's. Further review showed there was no evidence the facility responded to the grievances or communicated resolution to the resident council. 4. Review of resident council meeting minutes dated 8/30/16 showed resident concerns included food quality, food choices, food preparation carts, laundry services, and outdoor activities. Further review showed there was no evidence the facility responded to the grievances or communicated resolution to the resident council. 5. Interview with the activities director on 9/9/16 at 11:02 AM revealed any concerns that come out of the resident council meetings were supposed to be tracked on social services logs, and further stated a resident council response form was used for concerns generated in the council. The activity	F 244	Dining room monitors will complete a random audit of two (2) meals per day, five (5) times per week for four (4) weeks to ensure that Residents sitting at tables are served timely, that staff are hand washing as appropriate and staff have appropriate behavior during dining service Social services will audit the podiatrist for compliance to the process of seeing and treating residents in the facility with each monthly visit for three (3) months. 4. **Monitoring** The Director of Nursing Services or designee will report results of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as determined by the committee. F244 Listen/Act on Group Grievance/ Recommendation 1. **Corrective Action**	10/05/2016

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F 244	Continued From page 4 director stated no concerns had been identified from the council meetings for the previous 3 months.	F 244	An audit of the facility Resident Council minutes from June, July and August 2016 were reviewed to ensure the facility responded or resolved the grievance. Outstanding resident grievances were resolved on or by 10/05/2016. 2. Activities Director or Designee to ensure Residents were interviewed/ audited during resident council on 09/27/2016 and any grievances reported are resolved and/ or responded to the resident on or by 10/05/2016. 3. Activities Director or Designee to complete a random monthly audit of resident council grievances to ensure resident council grievances are responded to and/or resolved. 4. Activities Director or Designee will ensure that all new resident council grievances are reported on a "grievance from" for individual grievances and distributed to the Social Services Director or designee to be logged on the grievance	
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 4 of 4 resident areas (First, Second Floor, Third Floor, Reflections Unit) were clean and in good repair. The findings were: Observation on 9/8/16 from 4:15 PM through 5:15 PM revealed the following environmental issues: 1. The following issues concerning doors and door frames were identified: a. The door to the ice machine area off of the first floor dining room had an area on the right frame broken loose from the floor that measured 33 inches up which created an uncleanable surface. b. The two entrance doors to the main dining area on the first floor had a 9 inch by 72 inch area across that was darkened with dirt and debris to which created an uncleanable surface. c. The bathroom door in room #220 facing the room had a 6 inch by 3 inch hole at the bottom of the door. The inner bathroom door area by the hinges was separating from the floor that measured 40 inches up which created an	F 253		

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F 253	Continued From page 5 uncleanable surface. d. The inner bathroom door in room #222 had a chip at the bottom that measured 14 inches up which created an uncleanable surface. e. The inner bathroom door in room #217 had gashes at the bottom that measured 20 inches up across the 36 inch floor which created an uncleanable surface. f. The second floor central supply door facing the hallway had kickplate damage with a missing area 4.5 inches across and 9 inches long. g. The front door to room #228 had kickplate damage 36 inches across. h. The bathroom inner door kickplate in room #227 had an area torn off 12 inches by 16 inches. i. The kickplate on the front door of room #225 was damaged on the inside at the bottom that measured 36 inches up. j. The fire doors in the hallway outside of room #225 both had damage at the bottom that measured 38 inches up with missing chips on the hinge side. k. The front door kickplate to room #207 had gashes in each side from the floor that measured 36 inches up. l. The bathroom door in room #203 had 4 holes with the largest hole measuring 2 inches in diameter. The doorframe on the right had damage from the floor that measured 48 inches up which exposed metal and created an uncleanable surface. m. The bathroom door in room #320 had a 5 inch by 4 inch hole at the bottom. n. The bathroom door in room #319 had two holes, the largest which measured 2.5 inches by 2 inches. o. The bathroom door of room #309 had one hole that measured 2 inches by 3 inches, and another hole that measured 4.5 inches by 4.5	F 253	log and distributed to the appropriate team leader for resolution. The completed resolution and/or response will be reported back to the resident council the following month on a "resident council response form". Results of the Resident Council Response form will be reported to the facility Quality Assurance Meeting by the Activities Director or designee monthly for 90 days or until substantial compliance has been achieved or sustained as determined by the committee. F253 Housekeeping & Maintenance Service 1. <u>Corrective Action</u> The Maintenance Director or designee have completed the follow: a. The door frame to the ice machine area off of the first floor dining room was repaired on or before 10/05/2016. b. The entrance doors to the first floor main dining room	10/05/2016

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F 253	Continued From page 6 inches. p. The closet door in room #301 had paint scraped off on the left at the bottom that measured 20 inches up. The front door of the room had a crack along the hinges at the bottom that measured 18 inches up. This damage created an uncleanable surface. 2. The following issues concerning floors were identified: a. The exit door on the first floor dining area (currently used for activities) had a missing threshold 36 inches across. The area of the missing threshold under the door was collecting darkened dirt and debris, and the outside could be seen between the bottom of the door and the floor. Also, the right side of the door was dirty from the floor to the top of the door. b. One tile to the right of the ice machine door in the first floor dining area had a circular hole 2.5 inches in diameter. This hole was darkened and created an uncleanable surface. c. The wooden and black rubber divider strip 36 inches long and 12 inches wide between the main dining room area on the first floor and the ice machine room was damaged with wear and scrapes, which collected dirt and debris and created an uncleanable surface. d. The floor in the dining area behind the second floor nursing station by the front door had 2 chips through the tile, the largest measured 2 inches by 1 inch. The areas were darkened with dirt and debris, and the damaged area was an uncleanable surface. Two 12 inch by 12 inch tiles near the door were brown stained. e. The floor against the outer windows in the second floor main dining area was dirty and damaged 52 inches across, which created an uncleanable surface.	F 253	floor was cleaned on or before 10/05/2016. c. The bathroom door hole and separation near hinge to room #220 was repaired on or before 10/05/2016. d. The bathroom door chip in room 222 was repaired on or before 10/05/2016. e. The bathroom door gashes in room 217 was repaired on or before 10/05/2016. f. The 2nd floor central supply door damaged kick plate has been repaired on or before 10/05/2016. g. The front door damaged kick plate to room 228 was repaired on or before 10/05/2016. h. The bathroom inner door torn kick plate was repaired on or before 10/05/2016. i. The front door damaged kick plate to room 225 was repaired on or before 10/03/2016. j. The damaged hallway fire doors with chips on the hinge side outside of room 225 was repaired on or before 10/03/2016. k. The front door kick plate gashes to room 203 was	

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F 253	Continued From page 7 f. The floor of the shower area to the east of the elevators on the second floor had a darkened mold-like substance along the edges between the floor and wall for all four walls. The floor to wall corners to all walls outside of the shower had damaged grout that created an uncleanable surface and had become brownish. g. The floor by the back bed in room #229 had 10 tiles which each measured 12 inches by 12 inches and were darkened and dirty with dirt and debris. The toilet in the bathroom had missing and damaged caulk between the toilet base and floor that was urine colored and created an uncleanable surface. h. The floor by the front door in room #226 had tile damage 16 inches across which was darkened with dirt and debris and created an uncleanable surface. i. The toilet in the bathroom of room #210 had missing and damaged caulk between the toilet base and floor that was urine colored and created an uncleanable surface. j. The threshold to the front door of room #325 had stains on the floor which measured 8 inches by 42 inches. k. The front of the floor to the Reflections Unit shower room had dirty duct tape 24 inches across. l. The "Office" door across from the third floor Nursing Station had baseboard in the hallway to the left that was damaged 8 inches across and was opened at the wall seam. This damage created an uncleanable surface. m. The dining area behind the third floor nursing station had a missing baseboard on the left wall area that measured 4 inches by 4 inches. An area on the right wall had a 4 inch by 4 inch darkened and dirty area. n. The floor against the outer windows in the	F 253	repaired on or before 10/03/2016. l. The bathroom door holes and doorframe exposed metal was repaired on or before 10/05/2016. m. The bathroom door hole in room 320 was repaired on or before 10/05/2016. n. The bathroom door holes in room 319 were repaired on or before 10/05/2016. o. The bathroom door holes in room 309 was repaired on or before 10/05/2016. p. The closet door areas of room 301 scraped off paint and the front door hinge area were repaired on or before 10/05/2016. q. The exit door on the first floor dining area threshold was repaired and cleaned on or before 10/05/2016. r. The tile hole to the right of the ice machine door on the 1st floor was repaired on or before 10/05/2016 s. The main dining room area on the first floor, wooden and black divider strip and ice machine room wear, scrapes, dirt and debris was repaired and cleaned on or before 10/05/2016.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 253	Continued From page 8 third floor main dining area was dirty and damaged 52 inches across, which created an uncleanable surface. There was 36 inches of the damage that exposed metal. 3. The following miscellaneous issues concerning facility cleanliness and maintenance were identified: a. A ceiling vent cover 24 inches by 24 inches at 6 feet from the exit door in the main dining area on the first floor was covered with gray dust. b. The heat vent in the bathroom of room #212 was scraped and rusted 36 inches across with paint chips on the floor. The damage created an uncleanable surface. A circular vent cover in the ceiling 10 inches in diameter was rusted around the cover. c. The tub in the tub and shower room, to the east of the elevators on the second floor, had items stacked in the tub which included wheelchair footrests, wheelchair cushions, and a walker. A hoyer lift was against the tub. The items in the tub were collecting dust and debris, and the clutter created an uncleanable environment. The ceiling had a vent cover 8 inches by 14 inches that collected dust. The metal edges of the ceiling light were rusted on all sides with chipped paint that was dropping on the floor. d. The sink located at the assisted dining area on the second floor outside of the DON's office had the baseboard loose to the right of the sink cabinet from the floor to 5 inches up. The area was darkened with dirt and debris. e. A sit-to-stand lift located in the bathroom of room #229 was dirty with multiple whitened and brownish stains. f. The towel rack in the bathroom of room #225 was torn from the wall.	F 253	t. The dining area behind the nursing station on 2nd floor had chips and a stain in the tile that was repaired and cleaned on or before 10/05/2016. u. The 2nd floor main dining area against the outer windows was dirty and damaged was cleaned and repaired on or before 10/05/2016. v. The 2nd floor shower area to the east of the elevator was cleaned and grout repaired on or before 10/05/2016. w. The tiles in room 229 near bed B and bathroom floor was cleaned, and the caulking around the toilet was caulked on or before 10/05/2016. x. The front door floor tile in room 226 was repaired on or before 10/05/2016. y. The toilet in room 210 was caulked and the bathroom floor was cleaned on or before 10/05/2016. z. Front door floor threshold stains in room 325 was repaired on or before 10/05/2016. aa. The Reflections Unit shower room dirty duct tape	

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F 253	Continued From page 9 g. The ceiling in the Reflections Unit shower room had various spots with paint chips and rusted areas. The towel rack was also loose. h. The air conditioner at the third floor main dining area had dirt and gray dust underneath at the vented area, and the vent cover was loose. i. The heater vent cover in the bathroom of room #212 was rusted 6 inches up and 36 inches across, and had chipped paint and darkened dirt and debris. 4. Tour with the maintenance director on 9/9/16 at 10:20 AM confirmed the issues with building damage. The maintenance director stated he intended to repair the issues. However, the facility failed to have a plan with a timeframe for those repairs. Interview with the housekeeping supervisor on 9/9/16 at 11:15 AM confirmed the areas of the building found to be dirty were in need of housekeeping attention.	F 253	was removed and cleaned on or before 10/05/2016. bb. The "office" door across from the third floor Nursing Station baseboard in the hallway to the left was repaired on or before 10/05/2016. cc. The dining area behind the third floor nursing station had a missing baseboard on the left wall area was repaired and the right wall was cleaned on or before 10/05/2016. dd. The floor against the outer windows in the third floor main dining area was cleaned and repaired on or before 10/05/2016. ee. The ceiling vent near the exit door in the main dining area on the 1st floor was cleaned on or before 10/05/2016. ff. The heat vents I the bathroom of room 212 was repaired on or before 10/05/2016. ff. The tub in the shower room east of the elevators on 2nd floor was decluttered and cleaned as well as the ceiling vent was cleaned and the ceiling light was repaired on or before 10/05/2016.	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of policy and procedures, the facility failed to ensure 1 of 3 (#15) residents with constipation received	F 309		

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F 309	Continued From page 10 appropriate care and treatment. This failure resulted in hospitalization and actual harm to the resident. In addition, the facility failed to provide timely assessments for 1 of 13 sample residents (#6) with falls. The findings were: 1. Review of the 7/25/16 annual MDS assessment showed resident #15 had diagnoses that included non-Alzheimer's dementia, depression, and diabetes mellitus. Additionally, the resident required total assistance of 1 or more persons for toileting, was always incontinent of bowel and bladder, did not have a toileting program, and did not have constipation present. Review of the July 2016 medication administration record (MAR) showed the resident received a fentanyl duragesic patch (narcotic transdermal patch) 75 mcg/hr (micrograms per hour) every 72 hours and oxycodone-acetaminophen 5mg (milligrams)-325 mg by mouth 2 times per day for pain management. Further, the resident received Lexapro (anti-depressant) 10 mg by mouth every day. The following concerns were identified: a. Review of the "Resident Functional Performance Record" for July 2016 showed the resident had a large bowel movement documented on 7/26/16. This was the only recorded bowel movement on this document for 13 days between 7/20/16 and 8/1/16. b. Review of the MAR for July 2016 showed the resident had an order for docusate sodium (stool softener) 100 mg by mouth every day as needed; however, there was no evidence the medication was administered during the month. Further, there was no evidence the facility's bowel protocol was implemented during July 2016 for the resident. c. Review of a nurse's note dated 7/25/16	F 309	gg. The sink located outside of the DNS office on the second floor baseboard was repaired on or before 10/05/2016. hh. The sit to stand located in the bathroom of room 229 was cleaned on or before 10/05/2016. ii. The towel rack in the bathroom of room 225 was repaired on or before 10/05/2016. jj. The ceiling in the Reflections Unit shower room and the towel rack was repaired on or before 10/05/2016. kk. The air conditioning vent in the 3rd floor main dining room was repaired and cleaned on or before 10/05/2016. ll. The heater vent cover in the bathroom of room 212 was repaired on or before 10/05/2016. mm. 2. <u>ID of Others</u> The Maintenance Director or designee completed an audit of resident care area doors have been repaired of any large broken/loose frames,	

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	535013	A. BUILDING _____ B. WING _____	C 09/09/2016

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F 309	Continued From page 11 and timed 10 PM showed the resident "yelled out in pain after being put to bed." Further, the note showed the resident stated "My rectum hurts" while having a bowel movement. d. Review of a nurse's note dated 7/26/16 and timed 6 PM showed the physician was notified because the resident kept complaining of rectal pain and was "yelling out a lot." Further, the note showed the resident stated "[s/he] yells sometimes for attention" and "[s/he] would yell even when someone wasn't touching [him/her]." The facility received an order for preparation H (a topical anesthetic for hemorrhoids) to be applied twice per day and as needed. e. Review of a nurse's note dated 7/28/16 and timed 12:45 AM showed the resident "continues to cry out when turned or care given off and on." f. Review of a nurse's note dated 7/29/16 and timed 3:30 AM showed the resident "yells out in pain during incontinence care." g. Review of a nurse's note dated 7/30/16 and untimed showed the resident "still yells out a lot." h. Review of a nurse's note dated 7/31/16 and timed 3 PM showed the resident "continues to yell out" after pain medications were administered. i. Review of a nurse's note date 8/1/16 and timed 2 PM showed the physician was notified of staff and family's pain concerns. Further, the note indicated the resident was transported to the emergency department by ambulance at 1:55 PM. j. Review of the hospital discharge summary dated 8/4/16 and timed 3:19 PM showed the resident had an ileus, and obstipation (severe or complete constipation) was identified on a computed tomography scan from the emergency	F 309	chipped, gashed, damaged kick plate, holes, paint scraped or cracked also that floors have been repaired from any missing threshold/ holes, scraped, chipped, mold like, or damaged caulk, damaged or missing baseboard as well as ceiling and heating vents are repaired from damage, rust or dust on or before 10/05/2016 to ensure doors, floors and ceiling are in good repair. 3. <u>Systemic Change</u> The Maintenance Director and Environmental Services Director or designee to randomly audit two (2) times per week doors, floors, ceilings and vents to assess, repair and/or clean any newly discovered areas. 4. <u>Monitoring</u> The Maintenance Director and Environmental Services Director or designee will report results of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved	

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F 309	Continued From page 12 room. Further, the resident was not able to receive manual disempaction (removal of stool) due to the stool being high up in the rectal vault. k. Review of a nurse's note dated 8/4/16 and timed 5:45 PM showed the resident returned from the hospital with a diagnosis of ileus (inability of the intestine to contract normally and move waste out of the body). l. Review of the "Resident Functional Performance Record" for August 2016 showed the resident had no bowel movement charted for 5 days from 8/9 through 8/13, 3 days from 8/17 through 8/19, and 4 days from 8/23 through 8/26/2016. Review of the MAR for August 2016 showed there was no evidence the bowel protocol was implemented when the resident had no documented bowel movement for more than 3 days. m. Review of the policy title "Bowel Protocol" last updated July 2014 showed "...1. Each resident is placed on a daily bowel monitoring program. 2. For residents at risk for constipation/fecal impaction, the following care plan interventions are implemented: a. Initiate hydration program. b. Increase fiber in diet (refer to the diet manual for details). c. Increase exercise and physical activity (restorative and/or activities). d. Initiate a toileting/retraining program. e. Administer stool softener per physician order. 3. The licensed nurse reviews the bowel monitors daily. 4. If a resident does not have a bowel movement for 3 days administer Milk of Magnesia per physician order on day 4. 5. If Milk of Magnesia offers no results, administer a stimulant laxative suppository (Biscodyl, etc.) per physician order on day 5. 6. If resident continues to have no results from suppository, administer an enema within 4-6 hours of receiving suppository. 7. If no results	F 309	or sustained as determined by the committee. F309 Provide Care/ Services for Highest Well Being 1. <u>Corrective Action</u> Resident #15 has returned to the facility, resident's bowel regime is being followed and documented on the functional performance record. Resident has had no significant complaint of pain or excessive days without BM. Resident #6 was assessed and evaluated and an incident report was completed. Corrective action was completed with identified staff members and the incident was reviewed in the Interdisciplinary Team meeting. 2. <u>ID of Other</u> Residents who reside in the Center have the potential to be affected. The Director of Nursing Services or designee completed an audit of current resident Bowel movement	10/05/2016

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F 309	Continued From page 13 from enema, notify physician." n. Interview with the DON on 9/9/16 at 3 PM revealed nurses should have implemented the facility's "bowel protocol" for residents without a bowel movement for 3 days or more to prevent impaction. 2. Review of the 7/19/16 admission MDS assessment showed resident #6 had diagnoses that included atrial fibrillation, hypertension, diabetes mellitus, and non-Alzheimer's dementia. Additionally, the resident required supervision for transfers, bed mobility, and toilet use. The following concerns were identified: a. Continuous observation on 9/6/16 between 4:05 PM and 5:18 PM showed the resident was in his/her room kneeling on a pillow that was positioned on the floor. The resident was leaned back against the footrest of the recliner which was pushed nearly to a closed position. CNA #1 observed the resident on the floor and asked the resident if s/he was okay and turned on the call light to notify the nurse. LPN #1 entered the resident's room where she was informed by the CNA that she knew the resident was not to be moved and she needed to get help. The LPN stated at that time, "It wasn't really a fall." Further, the LPN and CNA assisted the resident off the floor by placing their hands under the resident's arms and lifting him/her to a standing position. The CNA then assisted the resident to the restroom with a walker; however, a gait belt was not used. After using the restroom, the resident was assisted to ambulate to the dining room. After the resident was found kneeling on the floor, there were no vital signs obtained and no neurological or physical assessment completed on the resident. b. Review of an interdisciplinary progress	F 309	(BM) records on or before 10/05/2016 to ensure the BM protocol is being followed. The Director or Nursing Services or designee completed random staff interviews to inquire, that based on the fall management education provided on the description of a fall, "unintentional change in position coming to rest on the ground, floor or onto the next lower surface"; if any residents met the criteria and needed to be assessed. No further findings of concern identified. 3. <u>Systemic Change</u> The Director of Nursing Services re-educated nursing staff regarding fall management and documentation of BM's on 9/14/16 and 9/29/16, the education included where and when to document, why documentation is important, and what happens when documentation is not completed.	

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F 309	Continued From page 14 note dated 9/6/16 and timed 5 PM showed "[resident's name] attempted to get out of [his/her] reclyner (sic) this afternoon-[s/he] scooted to the ft (foot) rest when staff noted [him/her]- Pt (patient) ed (education) given on call light use..." c. Review of an interdisciplinary progress note dated 9/7/16 at 1 AM showed the resident had increased confusion and was assisted to bed with his/her walker. d. Review of an interdisciplinary progress note dated 9/7/16 at 7:50 PM showed the physician was notified to follow up on abnormal lab values. The facility received an order to send the resident to the emergency room for evaluation and treatment. e. Interview with the DON on 9/9/16 at 11:43 AM revealed the RAI manual version 3.0 was the facility's reference for the definition of a fall. f. Review of the CMS Resident Assessment Instrument (RAI) manual version 3.0 showed a fall as an " ...Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g. onto a bed, chair, or bedside mat)..." g. Review of the facility policy titled "Fall Evaluation and Management" updated January 2016 showed "...Post-Fall Documentation: 1. The center utilizes the Fall Scene Investigation Report to assist with post-fall evaluation. 2. After the resident has been evaluated and cared for, the licensed nurse: a. Completes an interdisciplinary progress note, including a brief summary of the fall, the nursing evaluation, actions taken, who was notified, and the resident's condition. b. The nurse completes orthostatic vital signs as listed above. c. The nurse completes a blood glucose reading at the time of the fall (only if diagnosed diabetic). d. Updates the care plan with newly	F 309	The Director of Nursing or Designee will complete an audit of the functional performance records for BM management daily times 30 days, then weekly times two (2) months. The Director of Nursing or Designee will randomly interview staff 5 times per week for four (4) weeks to inquire if any resident met the criteria of a fall. 4. **Monitoring** The Director of Nursing Services or designee will report results of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as determined by the committee. F323 Free of Accident Hazards/ Supervision/ Devices 1. **Corrective Action** Resident #15, #38 and #45 was assessed for the size of sling to be used during transfer via Hoyer, education	10/05/2016

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F 309	Continued From page 15 identified interventions, as needed.... f. Alerts following shifts to fall and care plan/care directive changes per protocol. g. Resident is monitored for 72 hours post fall. h. Follows up with the physician and responsible party, as needed, to provide updates. i. Continues to follow the resident every shift for the next 72 hours, documents findings and resident condition in the Nurse's Notes..."	F 309	was provided to the C.N.A.'s regarding safe use of a Hoyer, education was provided to where extra slings are kept and how to select the size and type of sling to use for resident individualization.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, policy and procedure review, and review of manufacturer's recommendations, the facility failed to ensure safe transfers were completed for 3 of 13 sample residents (#15, #38, #45) who used a mechanical lift. In addition, the facility failed to ensure 5 of 6 hallways (second floor A hall, second floor B hall, second floor C hall, third floor A hall, third floor B hall) were clear of unsafe environmental factors, and 1 of 7 medication storage areas (Reflections Unit medication cart) were secure while not in use. The findings were: 1. Observation on 9/6/16 at 4:40 PM showed CNA	F 323	The medication cart on Reflections Unit was secured immediately upon findings and education was provided immediately to the nurse by the Executive Director on 09/09/2016. Room #212, #220,#226 ,#229, the dining area of the Reflections Unit, #320, 3rd floor nurses station and #307 with loose heater vent covers will be repaired by the Maintenance Director or Designee on or before 10/5/16. The fire extinguishers outside of room #211 and outside of room #320 will be repaired by the Maintenance Director or	

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F 323	Continued From page 16 #2 and CNA #3 used a mechanical lift with a sling that had green trim to transfer resident #15 from bed to a wheelchair. The CNAs confirmed at that time the sling was too big for the resident; however, a smaller one was not available at that time. Further, there was a fall mat on the floor by the bed and the wheels of the lift were rolled over the mat while the resident was in the sling. Review the manufacturer guidelines of the mechanical lift slings showed that the size large sling with green trim was appropriate for residents weighing 70-120 kilograms (154-264 pounds); however, the most recent weight recorded for the resident, dated 9/4/16, was 99 pounds. The manufacturer recommended sling for this weight was a small sling with red trim, appropriate for 35-60 kilograms (77-132 pounds.) 2. Review of "tollos (sic) Ultralift Electric Lifter User Manual" dated 2/20/13 showed "...Safety Information...visibly inspect sling prior to each use to ensure sling is the correct type, size and design to handle lifting;...Raising the Resident...WRONG SLING SIZE CAN ALLOW RESIDENT TO FALL OUT-READ SLING USER GUIDE...Transporting the Resident 1. Roll the lift onto a smooth, unobstructed surface when transporting a resident..." 3. Observation on 9/6/16 at 5:02 PM showed CNA #2 and CNA #4 entered resident #38's room with a full body lift. The CNAs assisted the resident to sit forward and placed the sling around the resident and attached it to the lift. CNA #2 raised the resident in the lift and positioned it over the resident's bed. During the transfer, the mechanical lift traveled over a fall mat that was left in the pathway. After providing care, the sling was attached to lift and the resident was lifted	F 323	Designee on or before 10/5/16. 2. <u>ID of Others</u> Any resident utilizing a Hoyer lift can be affected. Director of Nursing or Designee will complete an audit of each resident using a Hoyer lift for appropriate sling size completed on or before 10/05/2016 and resident care directives have been updated with the size of the sling to be utilized for the resident. The Director of Nursing or designee will complete random visualization audits of environmental factors that are unsafe in hallways five (5) times per week. 3. <u>Systemic Change</u> Random Audits of medication carts being secured will be completed by the DON or designee five (5) times per	

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F 323	Continued From page 17 and transferred back to the resident's wheelchair. During the transfer, CNA #2 stated, "The fall mat makes it difficult to move the lift." 4. Observation on 9/6/16 at 11:20 AM showed CNA #7 and CNA #8 transferred resident #45 from the wheelchair to the bed. After securing the resident in the sling, both CNAs rolled the hoyer lift over a thick floor mat in order to position the mechanical lift above the bed. During transportation over the mat, the lift tipped slightly causing the resident to swing. 5. Interview with the DON on 9/9/16 at 3:30 PM revealed she believed the facility had a sufficient amount of slings in all sizes and was unsure why the CNAs assisting resident #15 didn't use the correct sling size. 6. Interview with the staff development coordinator on 9/9/16 at 10:55 AM revealed fall mats should be removed before moving the lift to ensure resident safety during transfers. 7. Observation on 9/9/16 at 12:56 AM showed the medication cart in the Reflections unit was not locked. At the time, there was not a nurse present in the unit; however, a CNA and a resident were near the medication cart. 8. Interview with the administrator on 9/9/16 at 1:20 AM verified medication carts should be locked if the nurse is not present. 9. The following concerns with loose heater vent covers were identified: a. The heater vent cover was off over the entire back wall of room #220, which exposed 2 metal cover fasteners with sharp edges.	F 323	week to ensure medication carts are secure. The Director of Nursing or Designee will complete a random visualization audit of a hands-on Hoyer lift transfer five (5) times per week to ensure the appropriate sling size and that staff are not rolling over the fall mat. Director of Nursing or designee provided the following education: Education was provided to the staff regarding Hoyer lifts, sizing slings, types of slings to use, and not rolling a Hoyer lift over a fall mat on 9/14/16 and 9/29/16. Education was provided to the staff regarding environmental hazards in hallways on 9/29/16. Education was provided to the nurses regarding securing medication carts on 9/29/16. Education was provided to the nurse identified individually along	

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F 323	Continued From page 18 b. The heater vent cap for the left end in room #212 was off, which exposed a 7 inch sharp metal edge. c. The bathroom heater vent cover was off over the entire side wall of room #229, which exposed 2 metal cover fasteners with sharp edges. d. The heater vent cover was off over 68 inches of the back wall of room #226, which exposed 3 metal cover fasteners with sharp edges. e. The dining area of the Reflections Unit had a heater vent cover off 72 inches across, which exposed 4 metal cover fasteners with sharp edges. f. The back hall heater vent cover outside of room #320 was off on the left side, which exposed 1 metal cover fastener with sharp edges. g. The back wall heater vent cover in the dining area behind the third floor Nursing Station was off 9 inches across, which exposed 2 metal cover fasteners with sharp edges. h. The wall in the hallway across from room #307 had a heater vent cap off that exposed a 10 inch by 4 inch metal edge that was sharp and dirty. 10. The following issues concerning fire extinguishers were identified: a. The hallway fire extinguisher well outside of room #211 had a missing cover which made the fire extinguisher unsecured. b. The hallway fire extinguisher well outside of room #320 had a Plexiglas cover that was cracked from top to bottom in multiple areas, which made the fire extinguisher unsecured. 11. Tour with the maintenance director on 9/9/16	F 323	with disciplinary action by the DNS on 09/09/2016. 4. **Monitoring** The Director of Nursing Services or designee will report results of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as determined by the committee. F364 Nutritive Value/ Appear, Palatable/ Prefer Temp 1. **Corrective Action** The milk was discovered as not at the correct temperature and discarded. 2. **ID of Others** The Dietary Manager or designee will complete an audit on or before 10/05/2016 of the temperature of Milk to ensure it was found to be at the correct temperature. 3. **Systemic Change** The Dietary Manager and/ or Dietician or Designee will randomly audit the	10/05/2016

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F 323	Continued From page 19 at 10:20 AM confirmed the issues with heater vent covers and fire extinguishers. The maintenance director stated he intended to repair the issues. However, the facility failed to have a plan with a timeframe for those repairs.	F 323	temperature of milk five (5) times per week to ensure the proper temperature of milk is maintained at time of service. Staff education on or before 10/05/2016 with regard to milk temperatures.	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure food was maintained at a temperature considered palatable during 1 of 2 meal observations (lunch meal service). The findings were: 1. Observation of the second floor noon meal on 9/8/16 showed a carton of milk was removed from the bin of ice, which was used to transport it from the kitchen at 12 PM and placed on a table next to the steam cart. The milk remained on the table throughout the meal service which ended at 1 PM. 2. A test tray was requested at 1 PM which included a glass of milk from the carton that had been sitting at room temperature for an hour. The temperature of the milk was taken with a digital probe by both the surveyor and the registered dietitian (RD). The temperature of the milk was 58.3 degrees Fahrenheit (F).	F 364	4. **Monitoring** The Dietician or Designee will report results of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as determined by the committee. F371 Food Procure, Store/ Prepare/ Serve- Sanitary 1. **Corrective Action** Items with an expired used by date were immediately discarded. 2. **ID of Others** The Dietary Manager or Designee will complete an audit on or before 10/05/2016 of the Walk in refrigerator, 2nd Floor Dining room refrigerator, 3rd Floor Dining room refrigerator and the	10/05/2016

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F 364	Continued From page 20 3. Interview on with the RD 9/8/16 at 1:05 PM revealed the expectation was milk should be kept on ice or refrigerated until the point of service. 4. Observation of a test tray on 9/8/16 at 1:05 PM showed two surveyors and the RD obtained the last food tray off of the service line and tested temperatures. One surveyor and the RD tasted the items on the tray. After the surveyor explained to the RD the milk on the tray had sat out between 12 Noon and 1 PM before being poured for the test tray, the RD refused to taste the milk because it had been out "too long." 5. According to Food Code 2013, U.S. Public Health Service: 3-501.16: " (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; or (2) At 5°C (41°F) or less."	F 364	Reflections Dining Room refrigerator to ensure containers are labeled with the appropriate "use by date" and items beyond the use by date are immediately discarded. 3. <u>Systemic Change</u> The Dietary Manager or Designee will complete a daily five (5) times per week audit of the Walk in refrigerator, 2nd Floor Dining room refrigerator, 3rd Floor Dining room refrigerator and the Reflections Dining Room refrigerator to ensure containers are labeled with the appropriate "use by date" and Items beyond the use by date are immediately discarded. Staff education on or before 10/05/2016 with regard to labeling containers/ food with the appropriate "use by date" and Items beyond the use by date are immediately discarded.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	4. <u>Monitoring</u> The Dietary Manager or Designee will report results of the audit to the facility monthly Quality Assurance	

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F 371	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure food was stored and distributed under sanitary conditions in 3 of 4 food storage areas (kitchen, second floor, Reflections Unit). The findings were: 1. Observation on 9/6/16 at 5:27 PM showed a clear container containing an orange liquid was served by an unidentifed staff member to residents in the second floor main dining room. The container had a label which stated "Use by 9/5/16." 2. Observation on 9/7/16 at 8:30 AM showed the refrigerator in the Reflections Unit, located in the area of the nurses' station, had two individual serving cups of orange slices, 6 individual serving cups of a yellow gelatin-like substance, a squirt bottle of applesauce and 1 individual serving cup resembling margarine with a use by dates of 9/6/16. Further, there was an unlabeled pitcher filled with liquid that resembled apple juice. 3. Observation on 9/8/16 at 9:25 AM showed the refrigerator in the Reflections unit had two individual serving cups of a yellow pudding-like substance, 5 individual serving cups of a yellow gelatin-like substance, a squirt bottle of applesauce, and 1 individual serving cup of orange segments all with a use by date of 9/6/16. Further, there was one individual serving cup of mixed fruit with a use by date of 9/7/16.	F 371	Meeting for 90 days or until substantial compliance has been achieved or sustained as determined by the committee. F441 Infection Control, Prevent Spread, Linens 1. <u>Corrective Action</u> The Director of Nursing or Designee to provide the following education on or before 10/05/2016: Resident #20, #38, #39, #45, #51, #52, #68 C.N.A. Education was provided to address changing gloves during cares, hand hygiene, catheter bag positioning, handling of linens, hand hygiene during meal service and assisting resident's during dining time, and reasons we cannot blow on resident's food to the staff. 2. <u>ID of Others</u> Residents who reside in the Center have the potential to be affected. Director of Nursing or designee to compete random audits on or before 10/05/2016 to observe C.N.A. cares with residents	10/05/2016

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F 371	Continued From page 22 4. Interview on 9/9/16 at 9:45 AM with the Dietary Manager revealed food stored in areas outside of the kitchen needed to be better monitored and outdated food thrown out. 5. According to Food Code 2013, U.S. Public Health Service: 3-501.17 "(A)...refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days."	F 371	including changing gloves during care, hand hygiene, catheter bag positioning, handling of linens and blowing on residents' food. 3. **Systemic Change** The Director of Nursing or designee provided nursing staff education on or before 10/05/2016to address changing gloves during cares, hand hygiene, catheter bag positioning, handling of linens and blowing on resident food. Director of Nursing or designee will randomly audits five (5) times per week for four (4) weeks to observe C.N.A. cares with residents including changing gloves during care, hand hygiene, catheter bag positioning, handling of linens and blowing on residents food. 4. **Monitoring** The Director of Nursing or Designee will report results of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441		

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F 441	Continued From page 23 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, medical record review, staff interview, and policy and procedure review, the facility failed to ensure infection prevention techniques were followed during 2 of 7 observations of perineal care (#20, #38), and 2 of 2 meal service observations (involving residents #39, #51, #52, #68). Additionally, the facility failed to ensure appropriate urine drainage bag placement for 1 of 1 sample residents (#45) with a urinary catheter. The following concerns were identified: 1. Observation on 9/6/16 at 4:05 PM showed CNA #2 provided perineal care to resident #20 who was incontinent of bowel and bladder. Further observation showed the CNA opened the resident's bedside dresser, obtained a new package of wipes, and placed placed the soiled	F 441	been achieved or sustained as determined by the committee. F456 Essential Equipment, Safe Operating Condition 1. **Corrective Action** The Maintenance Director or Designee repaired and defrosted the walk in freezer on or before 10/05/2016. 2. **ID of Others** The Dietary Manager or designee will complete an audit of the walk in Freezer to ensure there is no frost build up on or before 10/05/2016. 3. **Systemic Change** The Dietary Manager or designee will audit the walk in freezer three (3) times per week for four weeks then one (1) time per week until substantial compliance to ensure there is no frost build up. 4. **Monitoring** The Dietary Manager or Designee will report results of the audit to the facility monthly Quality Assurance Meeting for 90 days or until	10/05/2016

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F 441	Continued From page 24 gloved hand into the wipe container to obtain more wipes. Further, the CNA wiped stool from the resident's buttocks then transferred the soiled wipe her clean hand and threw the wipe in the waste basket. After providing perineal care, the CNA pulled up the residents pants and pulled down the resident's shirt without removing the soiled gloves. 2. Observation on 9/6/16 at 5:02 PM showed CNA #2 provided perineal care to resident #38 who was incontinent of bowel and bladder. Further observation showed the CNA applied a new incontinence brief, pulled up the resident's pants, and touched the mechanical lift and sling without removing the soiled gloves. 3. Interview with the staff development coordinator on 9/9/16 at 10:55 AM revealed staff should remove soiled gloves before touching clean items to prevent cross-contamination. 4. Observation on 9/6/16 at 11:55 AM showed LPN #1 assisted resident #52, #51, and #39 with their noon meal. During the observation, LPN #1 touched resident #52 and the resident's wheelchair and removed resident #39 milk from resident #51. The LPN then assisted residents to eat without performing hand hygiene. Further, the LPN left the table to refill resident #51 milk and cut the resident's food. The LPN returned to resident #52 and assisted the resident to eat without performing hand hygiene. 5. Observation on 9/6/16 at 12:43 PM showed CNA #6 was assisting resident #68 with his/her meal. The CNA had a bowl of unknown food and blew on the food while mixing it in the bowl before assisting the resident to eat it.	F 441	substantial compliance has been achieved or sustained as determined by the committee. F468 Corridors have Firmly Secured Handrails 1. **Corrective Action** The Maintenance Director or designee repaired the handrails on the second floor near the unit manager door, the handrails to the right of the second floor utility door and the handrails to the left of the reflections unit in the hallway on or before 10/05/2016. 2. **ID of Others** The Maintenance Director or designee will complete a facility wide audit of handrails on or before 10/05/2016 to ensure the handrails are firmly secured and safe to hold. 3. **Systemic Change** The Maintenance Director or designee will randomly audit handrails one (1) time per week to ensure the handrails are firmly secured and safe to hold.	10/05/2016

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F 441	Continued From page 25 6. Interview with the staff development coordinator on 9/9/16 at 9:15 AM revealed the facility expected staff members to perform hand hygiene in between assisting residents to eat and staff should not blow on resident food because it could increase the risk for resident infection. 7. Medical record review showed resident #45 was readmitted to the facility on 9/4/16 at 12:45 PM status post left hip fracture repair and a Foley catheter was inserted on 9/5/16 due to urinary retention. The following concerns were identified: a. Observation on 9/6/16 from 3:20 PM to 6 PM (2 hours and 40 minutes) showed the resident lying on his/her back with his/her head elevated at a 45 degree angle. During the observation, the resident's legs were bent at the knees with two pillows supporting them which also created a 45 degree angle. The resident's catheter bag was attached with straps above and below his/her left knee which prevented downward flow of urine. 8. Interview with the staff development coordinator on 9/9/16 at 9:15 AM revealed it was the expectation of the facility to have catheter drainage bags be kept below the level of the bladder to prevent urinary tract infections. 9. According to Lippincott Nursing Procedures seventh edition page 396 "...Position the drainage bag below the level of the patient's bladder to facilitate drainage and prevent stasis of urine, which increases the risk of CAUTI (Catheter-Associated Urinary Tract Infections)."	F 441	4. **Monitoring** The Maintenance Director or Designee will report results of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as determined by the committee. F505 Promptly Notify Physician of Lab Results 1. **Corrective Action** Resident #45 laboratory results were reported to the physician on or before 09/08/2016. 2. **ID of Others** Director of Nursing or Designee to complete an audit of all lab results on or before 10/05/2016 for the past 30 days to identify any other lab results that had not been reported to the physician. 3. **Systemic Changes** Director of Nursing or designee educated nursing staff on or before 10/05/2016 regarding following up on lab results.	10/05/2016.
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION	F 456		

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F 456	Continued From page 26 The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain essential equipment in a safe operating condition for 1 of 1 walk-in freezer. The findings were: 1. Observation on 9/6/16 at 11:10 AM showed the walk-in freezer had a buildup of frost on the shelving, exhaust fans, freezer strip door, and on the floor. 2. Observation on 9/9/16 at 8 AM showed the frost in the walk-in freezer continued to coat the exhaust fans, freezer strip door, and the floor. Further, the frost had obscured the food box labels on the top shelves of the freezer making the content of the boxes unreadable. 3. Interview with the maintenance director on 9/9/16 at 8:20 AM revealed he was aware of the problem, but did not have a plan with a timeline for repair. 4. Interview with the dietary manager on 9/9/16 at 9:45 AM revealed that the food in the freezer was available for immediate use. Further, she stated she was aware of the frost in the freezer and the maintenance manager was working on it.	F 456	Lab audits will be conducted weekly for the next 4 weeks, and continue until substantial compliance has been achieved or sustained. 4. **Monitoring** The Director of Nursing Services or Designee will report results of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as determined by the committee.	
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS	F 468		

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F 468	Continued From page 27 The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure handrails were firmly secured and safe to hold in 2 of 6 resident hallways (Second Floor B Hall, Reflections Unit). The findings were: 1. Observation on 9/8/16 at 3:50 PM identified the following loose and/or damaged handrails: a. The handrails on each side of the second floor unit manager door in the hallway were loose at 18 inches across each. b. To the right of the second floor utility door, the handrails were rough to the touch and the wood was splintered 47 inches across. c. To the left of the Reflections Unit in the hallway, one handrail was loose 8 inches across. 2. Tour with the maintenance director on 9/9/16 at 10:20 AM confirmed the issues with handrails. The maintenance director stated he intended to repair the issues. However, the facility failed to have a plan with a timeframe for those repairs.	F 468		
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff	F 505		

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F 505	Continued From page 28 Interview the facility failed to promptly notify the physician of laboratory reports for 1 of 13 sample residents (#45). The findings were: 1. Review of the medical record for resident #45 showed: a. A physician order for a TSH and Free T4 (laboratory tests to determine thyroid function) was to be done on 6/23/16. b. A final copy of the laboratory results dated 6/23/16 and printed on 9/2/16 was in the medical record. The report was faxed to the physician on 9/2/16 (71 days after the tests were completed). The report revealed both the TSH and Free T4 were not within the normal reference range for each analyte. c. New physician orders were received on 9/8/16 which increased the dose of levothyroxine (medication used to treat thyroid dysfunction) from 50 to 75 mcg per day. 2. Interview with the third floor unit manager on 9/9/16 at 11:40 AM verified this laboratory result was missed and was discovered through an audit.	F 505		