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

PRINTED: 10/13/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535022	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MANOR NURSING HOME	900 W 8TH ST GILLETTE, WY 82716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 9/26/16 through 9/29/16. Complaints reviewed in the course of this survey were complaint intakes WY000002126, WY000002248, and WY000002262. 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 CAA: Care Area Assessment 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	F 156	F156 **Correction for cited residents:** Facility notification board has been updated with contact information for State survey and certification agency. **Identification of other residents:** All residents have the potential to be affected by required postings not being accessible. **Systematic changes and Monitoring:** Audit will be conducted annually to ensure all required postings are posted and accessible to residents and visitors. **Outcome:** 100% of required postings will be posted in the facility and available for residents, visitors and staff to see. Administrator or designee will collect data from annual audit with discrepancies investigated and resolved Data will be aggregated on dashboard and reported annually at long term care quality meetings with action plans as appropriate.	11/13/16

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

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.

Jonni Belden Administrator 10-31-16

11/03/16 - 9:12 AM - Spoke c Jonni Belden administrator - POC accepted.

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F 156	Continued From page 1 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 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	F 156		

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F 156	Continued From page 2 numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State 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 State survey and certification agency information was prominently displayed. The findings were: Observation of the facility notification board on 9/28/16 at 5 PM showed no information for the State survey and certification agency was posted. Interview with the administrator on 9/29/16 at 10 AM confirmed the information was available to residents within the admission packet; however, it	F 156		

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F 156	Continued From page 3 was not posted elsewhere.	F 156	F 241	11/13/16
F 241 SS=E	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 resident, family, and staff interview, the facility failed to promote dignity during 3 of 3 observed meals. The findings were: 1. Review of the "LTC Nutritional Services Policy and Procedures" last revised on 4/30/16 showed neighborhood 5 (N5) meal service times were 11:15 AM for lunch and 5:15 PM for dinner. Further review showed the main dining room meal service time was 5:25 PM for dinner. The following concerns were identified: a. Observation of the neighborhood 5 (N5) dining room on 9/26/16 at 5:25 PM showed three dietary staff members serving eight tables for a total of 28 residents. Observation at 6:04 PM showed 3 tables had not yet received their dinner, while dessert was being served to all of the other tables. Further observation showed resident #99 received a meal tray at 6:03 PM and stated "This soup is barely even warm". One of the dietary staff members was summoned by the resident and warmed the soup in the microwave. At 6:15 PM the final table was served dinner (1 hour after the scheduled meal service time). b. Observation of the N5 dining room on 9/27/16 at 11:30 AM revealed 18 residents	F 241	<u>Correction for cited residents:</u> a.Resident #99 received cold soup, unable to remedy cold soup for that meal however temperature of soup will be maintained during service times. Microwaving of food is not acceptable during meal service times Meal service to be served per policy and per menu unless requested otherwise b.18 residents received meal 27 minutes after scheduled meal service time. Unable to remedy current meal service however supervisor to measure the time of meal service from beginning to end including adherence to scheduled meal service times. Meal service to be served per policy and per menu unless requested otherwise c.Resident #77 received frozen peanut butter and jelly crustees sandwich. Replaced with hand made peanut butter and jelly sandwich. Frozen snacks will be removed from kitchen to prevent reoccurrence Meal service to be served per policy and per menu unless requested otherwise d. 15 Residents concerned that meals are always late and sometimes wait 45 minutes to 1 hour to be served and food does not arrive hot. Pattern of delays and food temperature to be evaluated to determine root cause Unable to resolve that meal service for residents however delays in meal service result in decreased satisfaction, long waits, residents leaving table prior to finishing food resulting in potential weight loss and snacking unhealthy foods. Meal service to be served per policy and per menu unless requested otherwise. Meals to be at recommended temperature per policy. e. Heating of plates in microwave during meal service times immediately halted. Meal service to be served per policy and per menu unless requested otherwise	

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F 241	Continued From page 4 awaiting meal service. Continued observation showed the hot cart arrived at 11:36 AM and the first tray was served at 11:42 AM (27 minutes after the scheduled meal service time). c. Observation of the N5 dining room on 9/28/16 at 6 PM showed resident #77 was served a pre-packaged frozen peanut butter and jelly sandwich. After taking one bite, the resident threw the sandwich on his/her plate and stated "I don't want this crap, it is frozen in the middle. I want a real peanut butter and jelly sandwich." Dietary staff member #1 went to the kitchen and returned with a hand-made peanut butter and jelly sandwich at 6:15 PM. d. Interview with 16 residents on 9/27/16 at 1 PM revealed that 15 of the 16 residents were concerned that "meals are always late" and residents sometimes wait 45 minutes to 1 hour to be served. Further, they stated meals sometimes do not arrive hot but dietary staff members will warm food up when asked. e. Observation of the main dining room on 9/28/16 at 5:33 PM showed the dietary staff checked the temperature of the food on the steam table. The dietary staff then began plating items and microwaved the plates before delivering them to residents. f. Interview with resident #42 in the main dining room on 9/28/16 at 5:55 PM revealed s/he wondered if the meal service was taking so long because dietary staff was checking temperatures and heating the plates in the microwave and s/he had never seen them do that before. g. Observation of the main dining room on 9/28/16 at 6:05 PM showed resident #67 was seated at a table in the main dining room, with no food in front of him/her. Interview at that time revealed the resident was waiting for the meal to be served. The resident stated the meal was late,	F 241	F 241 continued f. #42 wondered why meals taking so long and checking temps and she had not seen them do it before. Meals to be at recommended temperature per policy. g. # 67 Meal was late Unable to resolve that meal service for residents however delays in meal service result in decreased satisfaction, long waits, residents leaving table prior to finishing food resulting in potential weight loss and snacking unhealthy foods. Meal service to be served per policy and per menu unless requested otherwise Meals to be at recommended temperature per policy. h. #61 meals often served late meal service often appeared Unable to resolve that meal service for residents however delays in meal service result in decreased satisfaction, long waits, residents leaving table prior to finishing food resulting in potential weight loss and snacking unhealthy foods. Meal service to be served per policy and per menu unless requested otherwise Meals to be at recommended temperature per policy. j. Residents received soup and sandwiches instead of the regular meal and delay in meal service. Unable to resolve that meal service for residents however delays in meal service result in decreased satisfaction, long waits, residents leaving table prior to finishing food resulting in potential weight loss and snacking unhealthy foods. Meal service to be served per policy and per menu unless requested otherwise. Meals to be at recommended temperature per policy.	

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F 241	Continued From page 5 and added "hopefully they'll serve soon... it's taking forever." Continued observation showed the resident was served the meal at 6:13 PM. h. Observation on 9/28/16 at 6:10 PM showed resident #61 and his/her family member sitting at a table in the main dining room, with no food in front of the resident. Interview at that time with the resident revealed meals were often served late. The resident added that evening staff assisted him/her to the dining room at 4 PM that evening, and s/he had been waiting "a long time sitting up" to be served. The resident's family member stated the meal service often appeared "very disorganized, even when they have a lot of staff" to help serve. Continued observation showed the resident was served the meal at 6:13 PM. i. Interview with the registered dietitian on 9/28/16 at 6:07 PM revealed serving the dining room should only take about 20 minutes. Further, the food on the steam table is supposed to be switched out with hot food from the kitchen after serving the 200 unit. j. Observation on 9/28/16 at 6:10 PM dietary staff began offering residents soup and sandwiches instead of the regular meal. Further observations at 6:20 PM hot items were taken from the kitchen and swapped with items on the steam cart. At 6:40 PM showed the last resident tray was passed, 67 minutes after meal service began. k. Interview with the registered dietitian on 9/29/16 at 10:35 AM revealed the dietary department was down 2 full time employees and there was a call off on 9/28/16 which affected the evening meal service.	F 241	**Identification of other residents:** All residents have the potential to be affected by delayed meals, cold meals and long waits for meals. This results in cold food and residents leaving table prior to finishing meal. **Systematic changes and Monitoring:** 1. Meal service policies will be reviewed and revised as necessary to ensure resident satisfaction and proper meal serving. 2.Dietitian , Nutrition Supervisor and Director of Nursing will provide staff education related to provision of meals per policy, use of microwave and temp monitoring. 3. Evaluation of staffing schedules to ensure adequate staffing for all meal service times to provide meal service timely and efficiently with appropriate temperatures. 4. Audit tool developed to measure the timeliness of meals per policy. Data will be collected and monitored on the quality assurance dashboard monthly. 5. Nutrition leadership rounding during meal times to ensure adherence to policy regarding meal times, service and temp monitoring. Process improvement strategies will be implemented as needed. **Outcome:** 1. Residents will be served within designated time frames per policy. 2. Meals will be served within recommended temperatures ranges. 3. Nutrition supervisor or designee will collect data from audits monthly with discrepancies investigated and resolved with staff. Data will be aggregated on dashboard and reported monthly at long term care quality assurance meetings with action plans as appropriate.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE	F 250		

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F 250	Continued From page 6 The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure medically-related social services were provided for 1 of 1 sample residents (#16) with a need for dental services. The findings were: Review of the 8/25/16 annual MDS assessment showed resident #16 had diagnoses that included cachexia (a wasting syndrome). Review of the CAA for dental care, dated 9/2/16, showed "on a dental soft diet, dentures are supposedly in the works for repair." Review of the 8/25/16 progress note showed "Spoke with [CNA] down on N2 [neighborhood 2] for [the resident's] MDS interview and she stated that she had given [the resident's] top and bottom dentures to [family member] to send in to get fixed 'awhile' ago. She can't remember exactly when but says [the resident] has been on dental soft diet in the meantime. Notified social services to follow up on this." Observation of the resident on 9/27/16 at 12:28 PM showed his/her meal was a soft diet delivered in bowls. Interview with social worker #1 on 9/29/16 at 12:45 PM revealed her belief the resident's family	F 250	F250 **Correction for cited residents:** Resident #16 expired on 10/15/16, unable to resolve dental issue for this resident. Family notified on 09/29/16 and daughter stated she would be in the following week to get them. Despite communication with family, dentures were not picked up for repair. **Identification of other residents:** All residents have the potential to be affected by denture related issues with delay in follow up processes. **Systematic changes and Monitoring:** 1. Dental policies will be reviewed and revised as necessary. 2. Director of Nursing and Social Services will provide staff education regarding denture issues and follow up process. 3. Develop audit tool to audit charts and complaint software and audit monthly related to any denture related issues to ensure follow up is completed in a timely fashion per policy. 4. Review all residents in facility for denture use and issues to obtain baseline for denture status in facility. **Outcome:** 1. All residents with dentures will have timely follow up (7 days) per policy to resolve denture related issues. 2. Social Workers will collect data from audits monthly with discrepancies investigated and resolved with staff. Data will be aggregated on dashboard and reported monthly at long term care quality assurance meetings with action plans as appropriate.	11/13/16

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F 250	Continued From page 7 had taken the dentures to be repaired. Subsequent interview on 9/29/16 at 1:45 PM revealed the social worker had called the resident's family to inquire about the dentures, and was told the dentures had never been picked up. The social worker stated the resident's dentures had then been located in a cupboard at the nurses' station. She further revealed the facility did not have a system for tracking social service issues such as denture repair.	F 250		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures;	F 272	F272 Correction for cited residents: #5 CAA revision reference to date of assessment related to Nutritional status. Care plan reviewed for consistency with CAA and resident condition #7 CAA revision reference to date of assessment related to Falls and Nutritional status. Care plan reviewed for consistency with CAA and resident condition and supportive documentation for care plan #13 CAA revision reference to date of assessment related to Cognitive Loss/Dementia and Nutritional status. Care plan reviewed for consistency with CAA and resident condition #16 CAA revision reference to date of assessment related to Care plan reviewed for consistency with CAA and resident condition #21 CAA revision reference to date of assessment related to Cognitive Loss/Dementia, Visual Function, Urinary Incontinence indwelling catheter, Mood State, Behavioral Symptoms, Falls Nutritional status, Dental care, Pressure ulcers, Psychotropic drug use and Pain., Care plan reviewed for consistency with CAA and resident condition with supportive documentation to support the care plan decision. #41 #53 CAA revision reference to date of assessment related to Cognitive Loss/Dementia and Nutritional status. Care plan reviewed for consistency with CAA and resident condition #65CAA revision reference to date of assessment related to Delirium, Cognitive Loss/Dementia, Vision Function, Communication, ADL Function/Rehabilitation Potential, Falls and Nutritional status.	11/13/16

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F 272	Continued From page 8 Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the comprehensive analysis of resident needs in a variety of areas for 13 of 21 sample residents (#5, #7, #13, #16, #21, #41, #53, #65, #66, #69, #88, #89, #105). The findings were: 1. Review of the 7/28/16 significant change MDS assessment showed resident #13 triggered for comprehensive assessment for areas that included Cognitive Loss/Dementia and Nutritional Status. Review of the CAA for Cognitive Loss/Dementia showed only "staff provide cues and supervision." There was no comprehensive analysis of the resident's condition or needs. Review of the CAA for nutritional status showed only "regular diet with nutritional drinks TID [three times daily]." There was no comprehensive analysis of the resident's condition or needs. 2. Review of the 6/17/16 annual MDS assessment showed resident #21 triggered for comprehensive assessment for areas that included Cognitive Loss/Dementia,	F 272	F272 cont plan reviewed for consistency with CAA and resident condition #66 CAA revision reference to date of assessment related to Delirium, Cognitive Loss/Dementia, Communication, ADL function/Rehabilitation Potential Urinary Incontinence indwelling catheter, Mood State, Falls, Pressure ulcers, Psychotropic drug use and Care plan reviewed for consistency with CAA and resident condition with supportive documentation to support the care plan decision. #69 CAA revision reference to date of assessment related to Cognitive Loss/Dementia, Communication, ADL Function/Rehabilitation, Urinary Incontinence indwelling catheter, Psychosocial Well-being, Falls, Nutritional status, Pressure ulcers, Psychotropic drug use and Pain., Care plan reviewed for consistency with CAA and resident condition with supportive documentation to support the care plan decision. #88 CAA revision reference to date of assessment related to Cognitive Loss/Dementia, Visual Function, Urinary Incontinence indwelling catheter, Mood State, Behavioral Symptoms, Falls Nutritional status, Dental care, Pressure ulcers, Psychotropic drug use and Pain., Care plan reviewed for consistency with CAA and resident condition with supportive documentation to support the care plan decision. #89 CAA revision reference to date of assessment related to Cognitive Loss/Dementia and Nutritional status. Care plan reviewed for consistency with CAA and resident condition with supportive documentation to support the care plan decision. #105 CAA revision reference to date of assessment related to ADL Function/Rehabilitation Potential, Nutritional status, Psychotropic drug use and Pain., Care plan reviewed for consistency with CAA and resident condition with supportive documentation to support the care plan decision.	

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F 272	Continued From page 9 Communication and Nutritional Status. Review of the CAA for Cognitive Loss/Dementia showed only "Continuation of item on Care Plan." There was no comprehensive analysis of the resident's condition or needs. Review of the CAA for communication showed only "Has no speech r/t [related to] disease process," and the resident was at risk of having unmet needs. There was no comprehensive analysis of the resident's condition or needs. Review of the CAA for nutritional status showed only "CCHO [controlled carbohydrate diet] - with finger foods." There was no comprehensive analysis of the resident's condition or needs. 3. Review of the 8/25/16 annual MDS assessment showed resident #16 triggered for areas that included Visual Function and Nutritional Status. Review of the CAA for Visual Function showed only "Staff to monitor for impairment and help with visual deficits as appropriate." There was no comprehensive analysis of the resident's condition or needs. Review of the CAA for Nutritional Status showed only "high calorie, high protein, low sodium, dental soft - nutritional drink TID [three times daily]." There was no comprehensive analysis of the resident's condition or needs. 4. Review of the 8/12/16 admission MDS assessment for resident #5 showed Nutritional Status was one of the areas for additional assessment. Review of the CAA showed an analysis of data to support the care plan decision was lacking for the area. 5. Review of the 9/20/16 admission MDS assessment for resident #7 showed triggered areas which required additional assessment	F 272	**Identification of other residents:** All residents have the potential to be affected by incomplete comprehensive analysis of the CAA and insufficient data to support care plan decision. **Systematic changes and Monitoring:** 1. Policy and processes related to MDS will be reviewed and revised as needed. 2. MDS Consultant obtained to review MDS and CAA processes. 3. Consultant information utilized to complete staff education with documenting CAA utilizing RAI manual guidelines for comprehensive analysis of resident condition. MDS coordinator to provide education to staff completing the MDS sections and CAA 4. Clarification of documentation requirements with consultant MDS nurse. 5. Consult with Meditech analyst about revision of computer documentation system to discuss/implement required documentation elements. 6. Develop audit tool to review CAA for comprehensive analysis and sufficient data to support care plan data and complete audit monthly. **Outcome:** 1. A minimum of 95% CAA audits will reflect comprehensive analysis and supportive documentation to support care plan decision with 100% follow up with staff involved. 2. MDS coordinator or designee will collect data from audits monthly with discrepancies investigated and resolved with staff. Data will be aggregated on dashboard and reported monthly at long term care quality assurance meetings with action plans as appropriate.	

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F 272	Continued From page 10 included Falls and Nutritional Status. Review of the CAA showed analysis of data to support the care plan decision was lacking for these 2 areas. 6. Review of the 11/27/15 annual MDS assessment for resident #41 showed triggered areas which required additional assessment included Urinary Incontinence/Indwelling Catheter and Nutritional Status. Review of the CAAs showed analysis of data to support the care plan decision was lacking for those 2 triggered areas. 7. Review of the 6/10/16 annual MDS assessment for resident #53 showed triggered areas which required additional assessment included Delirium, Cognitive Loss/Dementia, Visual Function, Communication, ADL Function/ Rehabilitation Potential, Falls, and Nutritional Status. Review of the CAAs showed analysis of data to support the care plan decision was lacking in those areas. 8. Review of the 5/18/16 annual MDS assessment for resident #85 showed triggered areas which required additional assessment included Cognitive Loss/Dementia, Visual Function, Urinary Incontinence/Indwelling Catheter, Mood State, Behavioral symptoms, Falls, Nutritional status, Dental care, Pressure ulcers, Psychotropic drug use and Pain. Review of the CAAs showed an analysis of data to support the care plan decision was lacking for those areas. 9. Review of 8/8/16 annual MDS assessment for resident #66 showed triggered areas which required additional assessment included: Delirium, Cognitive Loss/Dementia, Communication, Urinary Incontinence/Indwelling	F 272		

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F 272	Continued From page 11 Catheter, Mood State, Falls, Nutritional Status, Pressure Ulcers, Psychotropic Drug Use, and Pain. Review of the CAAs showed an analysis of data to support the care plan decision was lacking for each of those areas. 10. Review of the 11/26/15 admission MDS assessment for resident #69 showed triggered areas which required additional assessment included Cognitive loss/Dementia, Communication, ADL Function/Rehabilitation Potential, Urinary Incontinence/Indwelling Catheter, Mood State, Falls, Pressure Ulcer, and Psychotropic Drug Use. Review of the CAAs showed an analysis of data to support the care plan decision was lacking for each of those areas. 11. Review of the 2/12/16 annual MDS assessment for resident #88 showed triggered areas which required additional assessment included: Cognitive loss/Dementia, Communication, ADL Function/Rehabilitation Potential, Urinary Incontinence /Indwelling Catheter, Psychosocial Well-Being, Falls, Nutritional Status, Pressure Ulcer, Psychotropic Drug Use, and Pain. Review of the CAAs showed an analysis of data to support the care plan decision was lacking for each of these areas. 12. Review of the 9/5/16 annual MDS assessment for resident #89 showed triggered areas which required additional assessment included Cognitive Loss/Dementia and Nutritional Status. Review of the CAAs showed an analysis of data to support the care plan decision was lacking for these 2 areas. 13. Review of the 1/5/16 annual MDS	F 272		

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F 272	Continued From page 12 assessment for resident #105 showed triggered areas which required additional assessment included ADL Function/Rehabilitation Potential, Urinary Incontinence/Indwelling Catheter, Nutritional Status, Psychotropic Drug Use, and Pain. Review of the CAAs showed an analysis of data to support the care plan decision was lacking for each of these areas. 14. Interview on 9/29/16 at 12:55 PM with the MDS coordinator revealed she had not received a lot of training on CAAs, and had "always questioned" how to complete them. She confirmed that some of the CAAs did not show a thorough analysis of the data.	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual	F 278	F 278 11/13/16 **Correction for cited residents:** Resident #89 section E on MDS was corrected and retransmitted to reflect the documented physical or verbal behaviors directed towards staff or rejection of cares. **Identification of other residents:** All residents have the potential to be affected by inaccurate MDS documentation. **Systematic changes and Monitoring:** 1. Policy and processes related to MDS will be reviewed and revised as needed. 2. Develop audit tool to review Section E specifically in conjunction with accuracy of the MDS. 3. Chart audits will be done on Section E for the accuracy of the MDS monthly. 4. MDS coordinator and MDS consultant to provide Staff education on documentation requirements will be completed regarding Section E. 5. Give social workers access to electronic medication record for review related to refusal of medications. **Outcome:** 1. A minimum of 95% of resident section E audits will accurately reflect the care provided with 100% follow up with staff involved. 2. MDS coordinator or designee will collect data from audits monthly with discrepancies investigated and resolved with staff. Data will be aggregated on dashboard and reported monthly at long term care quality assurance meetings with action plans as appropriate.	

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F 278	Continued From page 15 medical record as a basis for coding behaviors on the assessment. She further stated as long as behaviors were documented in the electronic medical record system, the behaviors should have been captured on the MDS assessment. 4. Review of the RAI manual, version 3.0, October 2014, MDS items section E showed: ..."Steps for assessment, 1. Review the medical record for the 7-day look back period. 2. Interview staff, across all shifts and disciplines...who had close interactions with the resident during the 7-day look back period,...3. Observe the resident in a variety of situations during the 7-day look back period". "Coding instructions Code..., behavior of this type occurred...If the behavior was exhibited...regardless of the number or severity of episodes that occur on any of those days".	F 278		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review,	F 325	F325 11/13/16 **Correction for cited residents:** Dietitian assessment completed on resident #69 Care plan updated with interventions. **Identification of other residents:** All residents have the potential to be affected by weight loss and failure to have Dietitian assessment. **Systematic changes and Monitoring:** 1. Revision of Weight Monitoring policy to reflect systematic changes of residents. 2. Daily rounding to discuss residents at risk for follow-up by dietitian. 3. Dietitian to provide education of nutrition tech to consult dietitian when screen identifies resident at risk. 4. Consult with Meditech analyst about revision of computer documentation system to generate order for RD consult for at risk residents. 5. Weekly weight review and report to DON or designee regarding residents with a 5% weight gain or loss. 6. Develop audit tool to monitor processes to assure at risk assessments are completed and complete chart review monthly. **Outcome:** 1.100% residents will have dietitian assessment per policy. 2. Nutrition supervisor or designee will collect data from audits monthly with discrepancies investigated and resolved with staff. Data will be aggregated on Quality dashboard and reported monthly at long term care quality assurance meetings with action plans as appropriate.	

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F 367	Continued From page 17 the facility failed to ensure residents received therapeutic diets as prescribed by a physician for 1 of 10 sample residents (#53) with therapeutic diet orders. The findings were: 1. Review of the 9/2/16 quarterly MDS assessment showed resident #53 had diagnoses that included Parkinson's disease and dysphagia (difficulty swallowing). Review of the physician order recapitulation dated 9/15/16 showed the physician ordered "Regular diet with pureed solids..." Review of the resident's "Altered Nutrition" care plan, dated 11/30/15, showed "I need foods pureed..." The following concerns were identified: a. Observation on 9/26/16 at 5:31 PM showed the resident was served the evening meal, consisting of a mechanical soft textured shredded pork with diced cooked carrots, mashed potatoes, and pureed broccoli. b. Observation throughout the rest of the survey, from 9/27/16 through 9/30/16, showed the resident received all pureed foods. c. Review of the dietary tray card showed instructions for the resident were "Regular diet; Mech. [mechanical] Soft- Level 1 Puree; With Gravy/sauces." The tray card was not clear whether the resident was to receive mechanical soft foods or pureed foods. d. Interview with the registered dietitian on 9/29/16 at 9 AM revealed the dietary servers use the tray cards as reference when preparing each resident's dish. She further confirmed the tray card showed both mechanical soft and pureed, and acknowledged it may have been confusing to dietary staff. Additionally, she revealed the resident required pureed foods to reduce the risk for aspiration or choking while eating.	F 367	F367 **Correction for cited residents:** Resident #53 1. Diet card corrected with correct ordered diet. 2. Care plan reviewed for correct diet. 3. Dietitian assessment completed on resident. **Identification of other residents:** All residents have the potential to be affected by incorrect diet cards and staff going by memory related to diet rather than using two patient identifiers. **Systematic changes and Monitoring:** 1. Review policy related to therapeutic diet preparation and delivery, revise as necessary. 2. Dietitian and nutrition supervisor will provide staff education related to 2 resident identifiers validation (picture and diet card prior to serving meals). 3. Develop audit tool for observation and review of diet cards monthly as accurate with physician order. **Outcome:** 1. 100% of the audited residents will have correct diet card per their order. 2. Nutrition supervisor or designee will collect data from audits monthly with discrepancies investigated and resolved with staff. Data will be aggregated on Quality dashboard and reported monthly at long term care quality assurance meetings with action plans as appropriate.	11/13/16

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F 425	Continued From page 18	F 425		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure expired medications were not available for use in 1 of 6 (secured unit) medication carts. The findings were: 1. Observation on 9/29/16 at 10:20 AM of the secured unit medication cart showed 3 prefilled blister packs of resident medications had expired. The following concerns were identified: a. Trazodone 50 mg tablets for resident #15 expired on 9/7/16. b. MAPAP (acetaminophen) 500 mg capsules	F 425	F425 11/13/16 **Correction for cited residents:** Expired cards were removed from the medication cart. **Identification of other residents:** All residents have the potential to be affected by expired medications. **Systematic changes and Monitoring:** 1. Policies and processes will be reviewed related to management of expired pharmaceuticals. 2. Director of Nursing will provide staff education related to noting expiration dates prior to administration. 3. Develop audit tool to monitor expired medications in medication carts and rooms monthly to ensure the removal of expired medications. 4. Pharmacy supplier to address conflicting expiration dates to ensure expiration date is consistent. **Outcome:** 100% of the audited medications in the facility will show no expired medications. DON or designee will collect data from monthly audit with discrepancies investigated and resolved. Data will be aggregated on dashboard and reported monthly at long term care quality assurance meetings with action plans as appropriate.	

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F 425	Continued From page 19 for resident #11 expired on 9/1/16 . c. MAPAP 325 mg tablets for resident #27 expired on 9/4/16. d. Interview with RN #2 on 9/29/16 at 10:20 AM verified the medications were available for resident use and were past their expiration date.	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	F441 11/13/16 **Correction of cited residents:** #5 on the spot education all rehab staff related to catheter placement while transferring or ambulating. (catheter bag must remain below the level of the bladder at all times.)Education for nursing and therapy staff on how to properly transfer residents with a catheter drainage bag. **Identification of other residents:** 1.All residents who have a catheter have the potential to be affected by inappropriate placement of the catheter bag **Systematic changes and Monitoring:** 1. Review/revise policies regarding cleaning disinfection/sanitizing after excretion of urine and feces and proper handling of catheter drainage bags. 2. Enhance leadership rounding tool to include observation and validation of proper sanitization processes when responding to body fluid spills and conduct monthly. 3. Director of Nursing and rehab supervisor to provide education with all direct care providers regarding catheter bag placement during ADL's. 4. Director of Nursing and Infection Prevention to provide education with all staff related to infection control process when responding to body fluid spills. 5. Develop and implement an audit process to observe residents with a catheter to assure proper catheter bag placement and conduct observations monthly.	

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F 441	Continued From page 20 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of policy and procedures, and review of the manufacturer's instructions, the facility failed to ensure infection prevention practices were followed by staff for 1 of 5 sample residents (#5) with indwelling urinary catheters. In addition, the facility failed to use use appropriate sanitation techniques during a random observation of environmental disinfection. The findings were: 1. Review of the 8/12/16 admission MDS assessment showed resident #5 had diagnoses that included arthritis and muscle weakness. Further review showed the resident had an indwelling urinary catheter. Review of the resident's care plan, dated 8/1/16, showed the resident had altered elimination and required "staff to assume all catheter cares..." The following concerns were identified: a. Observation on 9/27/16 at 11:24 AM showed RN #3 and physical therapist #1 positioning a transfer sling around the resident to transfer him/her from the bed to a wheelchair using a full body lift. The RN lifted the resident's urine collection bag and placed it on the resident's bed while securing the sling to the lift. After the sling was secured, the physical therapist lifted the urine collection bag above the level of the resident's bladder. Continued observation	F 441	F441 cont Outcome: 1. All residents with catheter will have catheter bag below the bladder at all times evidenced by 100% compliance. 2. Staff will be compliant with sanitizing areas where body fluid spills have occurred. 3. DON, EVS supervisor and Therapy supervisor or designee will collect data from monthly audit with discrepancies investigated and resolved. Data will be aggregated on dashboard and reported monthly at long term care quality assurance meetings with action plans as appropriate.	

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F 441	Continued From page 21 showed urine in the tubing flowed back toward the bladder. The urine collection bag was clipped to the sling above the resident's bladder for the duration of the transfer. b. Interview with RN #3 on 9/27/16 at 11:46 AM revealed the expectation was to keep the urine collection bag below the resident's bladder, and therapists "are not always aware" of that expectation. c. Interview with the infection control nurse #1 and infection control nurse #2 on 9/29/16 at 9:45 AM revealed the catheter drainage bag needed to remain below the resident's bladder to prevent backflow of urine into the bladder because it increased the resident's risk for catheter associated urinary tract infection. d. Review of the policy and procedure titled "Urinary Catheter Care," approved 8/3/15, showed "The drainage bag must be held/positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the bladder." 2. Observation on 9/27/16 at 9:30 AM showed CNA #2 and CNA #3 transferred resident #94 to a shower chair. The resident evacuated a large amount of stool onto the floor. CNA #2 wiped up the stool with wet wipes; however, housekeeping was not notified to disinfect the floor. Interview with housekeeper #1 on 9/28/16 at 12:10 PM confirmed that she was the housekeeper on that hall the previous day and she was not paged to the room for disinfection services. Interview with the housekeeping manager on 9/27/16 at 2:35 PM confirmed the infection control process for body fluids included "sanitation by a housekeeper after the CNA has cleaned the initial spill."	F 441		