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

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Healthcare Licensing and Surveys

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING _____ B. WING _____	11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LARAMIE CARE CENTER	503 S 18TH ST LARAMIE, WY 82070

(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 The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living ADON- Assistant Director of Nursing CAAs- Care Area Assessments CNA- Certified Nurse Aide DON- Director of Nursing Services MDS- Minimum Data Set MAR- Medication Administration record LPN- Licensed Practical Nurse RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law	F 225	F225 **Corrective Action:** The Grievance written for Resident # 51 was thoroughly investigated on 11/29/2016 which included interviews of other alert and oriented residents and staff members. No abuse or Neglect was identified. The incident was reported to the State Survey agency on 12/7/16. SY 12/30/16 **Identification:** Residents who reside at facility are at potential risk. On or prior to the allegation of compliance the NHA/Designee reviewed the last 30 days of grievances to identify other grievances regarding staff treatment that may not have been investigated. On or prior to the allegation of compliance the SSD/designee interviewed other alert and oriented residents and staff members regarding staff treatment. There were no further allegations of abuse or Neglect of residents SY 12/30/16 SY 12/30/16 **Systemic changes:** Beginning November 11/14/2016 and continuing up until the allegation of compliance the Staff employed at Laramie Health Care have been in serviced by SDC or designee regarding the timely and accurate investigation of all abuse/ Neglect allegations. Residents, families and staff will be able to report concerns, incidents and grievances without fear of retribution ~~by DON/designee~~ Facility supervisors will immediately correct and intervene in reported or identified situations in which abuse, neglect or misappropriation of resident property is at risk for occurring including conducting an investigation of an alleged abuse/neglect, misappropriation of resident property and reporting to appropriate agencies in accordance with state law. The investigation will include interviews of other residents as well as staff members. The facility will investigate all patterns, trends or incidents that suggest the possible presence of abuse, neglect to include Resident to Resident Altercations, identified through analysis conducted by the Quality Assurance and Assessment Committee, with intervention, reporting or policy/procedure modification conducted as appropriate. SY 12/30/16 SY 12/30/16 12/13/2016	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Andrea Stannard | TITLE: LNHA | (X6) DATE: 122916

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.

POC accepted with the agreed upon changes. NHA, Andrew Stannard, was contacted on 12/30/16 at 9:15am. Latest DOC was 12/13/16. Jean Yennie 12/30/16

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F 225	Continued From page 1 through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of a grievance, staff interview, and policy and procedure review, the facility failed to investigate and report allegations of abuse/neglect for 1 of 2 allegations reviewed (affecting resident #51). The findings were: 1. Review of a grievance dated 11/7/16 showed resident #51 had concerns which included alleged neglect related to personal care. The following concerns were identified: a. The grievance showed a CNA was assisting the resident with incontinence care that morning and the CNA "...told [the resident] she ran out of wipes..." The CNA then "... pulled up [the resident's] brief and pants and left [the resident] like that." Further, the grievance showed a nurse manager addressed the issue with CNAs and one-on-one education would be done with "everyone involved."	F 225	**Monitoring;** The nurse management team will monitor effectiveness of the system through review of the 24 hour report in the morning stand up meeting, and through investigation of incidents for patterns, or trends that may indicate the presence of possible abuse. The DON/Designee will review incident/accident reports and grievances monthly for three months then quarterly thereafter to ensure any incident/grievance that may indicate abuse has been investigated and appropriately reported if indicated. Issues identified will be presented by the DON/Designee to the quality improvement team to ensure the system has been implemented, sustained and evaluated for its effectiveness. Date of Compliance: December 12/13/2016	12/13/2016

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F 225	Continued From page 2 b. Interview on 11/16/16 at 11:40 AM with the ADON revealed education was verbally given to the CNA involved, but documentation of the education did not exist. c. Interview on 11/16/16 at 4:20 PM with the administrator verified they had not treated the complaint as an allegation of abuse/neglect and therefore it was not reported to the State Survey Agency or investigated. 2. Review of the facility policy titled "Abuse Prohibition and Prevention Program" revised 10/08 defined neglect as "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." In addition, "Any allegations involving mistreatment, neglect, or abuse...will immediately be reported to the Executive Director and appropriate state enforcement/regulatory agencies. A designated staff member of the community will conduct and complete an internal investigation..."	F 225		
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 7 of 11 resident areas (Pine Hall, North Spruce Hall, South Spruce Hall, Aspen Hall, Dining area 1, Dining Area 2, Activity Room) were clean and in good repair. The findings were:	F 253	F 253 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. 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 section 7305 of the state operations manual.	12/13/2016

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F 253	Continued From page 3 1. Observation on 11/16/16 at 10:50 AM showed the hallway floor outside room 25 had 2 tiles that measured 12 inches by 12 inches and were cracked, chipped, or broken, which created a surface that could not be cleaned. 2. Observation on 11/16/16 at 10:51 AM showed the hall floor by the 200 Unit Fire Doors on Pine hallway had 7 tiles that measured 12 inches by 12 inches and were cracked, chipped, or broken, which created a surface that could not be cleaned. 3. Observation on 11/16/16 at 10:53 AM showed the hall floor by the fire door near room 47 had 10 tiles that measured 12 inches by 12 inches and were cracked, chipped, or broken, which created a surface that could not be cleaned. 4. Observation on 11/16/16 at 10:55 AM showed the hallway floor outside room 46 had 7 tiles that measured 12 inches by 12 inches and were cracked, chipped, or broken, which created a surface that could not be cleaned. 5. Observation on 11/16/16 at 10:56 AM showed the hallway floor outside the North Spruce bathroom had 3 tiles that measured 12 inches by 12 inches and were cracked, chipped, or broken, which created a surface that could not be cleaned. 6. Observation on 11/16/16 at 11:01 AM showed the hallway floor between rooms 32 and 33 had 7 tiles that measured 12 inches by 12 inches and were cracked, chipped, or broken, which created a surface that could not be cleaned. 7. Observation on 11/16/16 at 11:27 AM showed	F 253	1. The observed two tiles outside hallway floor outside room 25 were replaced by maintenance. 2. The observed seven tiles by the 200 unit fire doors on Pine hallway were replaced by maintenance. 3. The observed ten tiles by the fire door near room 47 were replaced by maintenance. 4. The observed seven tiles outside room 46 were replaced by maintenance. 5. The observed three tiles outside North Spruce bathroom were replaced by maintenance. 6. The observed seven tiles between room 32 and 33 were replaced by maintenance. 7. The observed five tiles outside room 13 were replaced by maintenance. 8. The observed transition strip between dining room # 1 and dining room #2 was replaced and secured by contracted maintenance company. 9. Observed of the doorway between dining room #1 and dining room #2 that was closest to the kitchens four tile were replaced by contracted maintenance company. 10. The observed dining room #2 seven ceiling tiles were replaced or cleaned by maintenance and housekeeping. 11. The observed transition strip between dining room #2 and the Pine hall w was replaced and secured by contracted maintenance company. 12. The observed kitchen counter top in activity room will be replaced by date of compliance.	12/13/2016

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F 253	Continued From page 4 the hallway floor outside room 13 had 5 tiles that measured 12 inches by 12 inches and were cracked, chipped, or broken, which created a surface that could not be cleaned. 8. Observation on 11/16/16 at 11:30 AM showed the transition strip between dining room #1 and dining room #2, that was furthest from the kitchen, was visibly dirty with a black discoloration. Further, the transition strip was damaged and not secured to the floor. 9. Observation on 11/16/16 at 11:31 AM showed the doorway between dining room #1 and dining room #2, that was closest to the kitchen, had 4 tiles that measured 12 inches by 12 inches and were cracked, chipped, or broken, which created a surface that could not be cleaned. 10. Observation on 11/16/16 at 11:31 AM showed dining room #2 had 7 ceiling tiles that were damaged or dirty. Some of the tiles appeared to have been painted; however, there were large brown stains visible through the paint. 11. Observation on 11/16/16 at 11:32 AM showed the transition strip between dining room #2 and the Pine Hall was visibly dirty with black discoloration. Further, the transition strip was damaged and not secured to the floor. 12. Observation on 11/16/16 at 4:10 PM showed the kitchen counter top in the activity room was worn and had surface damage that created physical changes in the structure. 13. Interview with the maintenance director on 11/16/16 at 4:15 PM confirmed the damaged areas could not be cleaned effectively. Further,	F 253	Identification: Residents who reside in facility are at potential risk. Systemic Changes: Housekeeping and Maintenance Directors conducted visual rounds at the time of survey to identify other potential issues No other issues were identified.. Residents residing at the facility are at a potential for risk The NHA/Designee in-serviced the Housekeeping and Maintenance Director before date of compliance to ensure that the facility maintains a sanitary, orderly, and comfortable interior. Beginning at the time of survey and up to the date of compliance, the NHA/Designee in-serviced facility staff on communication of maintenance and housekeeping concerns/issues via log books located throughout the facility. On or before the date of compliance, the NHA/Designee in-serviced the housekeeping department on the importance of cleanliness of the facility. The housekeeping director, the maintenance director, and the facility management team will conduct visual rounds to ensure compliance. NHA will provide oversight to ensure identified issues have been addressed.	12/13/2016

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F 253	Continued From page 5 the interview revealed the facility had plans to replace the floors because the identified areas were continuing to break due to settling of the foundation.	F 253	Monitoring: The maintenance director, housekeeping director, and NHA/Designee will conduct monthly environmental rounds in order to identify outstanding housekeeping and maintenance issues with overall oversight provided by the NHA/Designee. Further monitoring through Resident Council, facility grievance process, ombudsman, and family feedback. Any issues identified will be addressed at that time and issues identified will be reported to the monthly QAPI committee meeting to ensure the corrections have been implemented, achieved, sustained and evaluated for its effectiveness. Date of Compliance: 12/13/2016	12/13/2016
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278		

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F 278	Continued From page 6 Based on medical record review, review of the Resident Assessment Instrument User's Manual, and staff interview, the facility failed to ensure the MDS assessment was certified as being complete in a timely manner for 3 of 14 sample residents (#2, #3, #37). The findings were: According to page 2-16 and 2-17 of "Long-Term Care Facility Resident Assessment Instrument 3.0 User's manual, Version 1.14" by the Centers of Medicare and Medicaid Services, the MDS completion date (item Z0500B) can be no later than the assessment reference date (ARD) plus 14 days for an annual or quarterly assessment. 1. Review of the quarterly MDS assessment for resident #3 showed an ARD of 8/8/16. However, the RN did not certify the assessment as being complete at section Z until 8/29/16 (21 days after the ARD). 2. Review of the quarterly MDS assessment for resident #2 showed an ARD of 8/14/16. However, the RN did not certify the assessment as being complete at section Z until 9/6/16 (23 days after the ARD). 3. Review of the annual assessment for resident #37 showed an ARD date of 8/21/16. Further review showed section Z of the assessment was not certified by the RN as complete until 9/23/16, 33 days later. 4. Interview with the MDS coordinator on 11/16/16 at 2:40 PM revealed assessments should be completed within 14 days of the ARD. Further, she revealed the assessments were late because there are "a lot of assessments due at the same time."	F 278	F278: December 13, 2016 Corrective Action: On or before of date of compliance the NHA/Designee re- educated the MDS staff responsible for the late MDS for resident's # 2,#3,#37 Identification Residents residing at Laramie Care Center are found to be potentially affected by the deficient practice. For Residents currently residing at Laramie Care Center a review was conducted to determine if any other assessments are past due. All other assessments were completed timely System Changes: The MDS nurse and Interdisciplinary Team will review the status of assessment completion each business day. MDS completion dates will be tracked at that time and the MDS nurse will ensure all the IDT have completed the assessment timely. On or prior to the allegation of compliance the NHA/Designee will in service the MDS staff and The Interdisciplinary Team with regards to timeliness of MDS completion. The MDS Nurse/Designee will oversee this process. Monitoring: The MDS Nurse//Designee will print the MDS due report weekly to determine if MDS assessments have been completed timely. Issues identified will be corrected at that time. The DON/Designee will report her findings to the Interdisciplinary Team at the Daily Leadership Meeting. The RN-MDS coordinator will report Negative trends to the QAPI team monthly and issues will be action planned and prioritized for process improvement. 5. Compliance date: December 13, 2016	

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F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview, and review of policies, the facility failed to ensure the plans of care were followed as written for 1 of 14 sample residents (#64). The findings were: 1. Review of the 10/23/16 annual MDS assessment showed resident #64 had moderate cognitive impairment, required extensive assistance for toileting, and was frequently incontinent of bladder. Review of the resident's care plan for incontinence, updated 10/28/16, showed approaches that included instructions for staff to toilet/check/change the resident upon rising in the morning, before and after meals, at bedtime and on rounds at night. The following concerns were identified: a. Continuous observation on 11/14/16 beginning at 11:25 AM showed the resident was seated in a wheelchair at the nurses' desk. At 12:10 AM CNA #1 wheeled the resident to the dining room for lunch without asking if the resident needed to use the toilet or offering toileting. b. At 12:55 PM, the resident self-propelled himself/herself to the activity room. None of the staff in the dining room asked if the resident needed to use the toilet or offered toileting assistance before s/he departed.	F 282	F282 Corrective Action: Resident 64 is now being toileted per his/her plan of care. The DON/ designee re- educated the staff on her/his plan of care specific to his/her toileting needs Identification Residents who reside in the facility are at risk. Systemic Changes: On or before the allegation of compliance the DON/Designee will re-educate the Licensed Nursing Staff and the C.N.A's on the importance of following the Resident's plan of care which included toileting per the resident individual care plan. PRN and Licensed Nursing Staff on leave will be re-educated upon return to work.	12/13/2016

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F 282	Continued From page 8 c. At 2 PM, activity assistant #1 wheeled the resident from the activity room to his/her room. The resident remained in the room until 2:20 PM when s/he self-propelled to the nurse's desk. At 2:25 PM, the resident returned to his/her room. At 2:30 PM (over 3 hours since the resident was first observed), while passing ice water, CNA #3 responded to the resident's request for assistance with personal hygiene care and toileting. The resident was observed urinating in the toilet. Interview with the CNA at that time confirmed the resident's incontinence brief was wet, and further revealed the resident was unable to perform toileting and incontinence care without staff assistance. The CNA also stated the resident had a hard time "holding it". d. During an interview on 11/16/16 at 3 PM, the DON stated the care plan was accurate and staff re-education was needed regarding following the care plan and offering toileting assistance.	F 282	Monitoring The DON/Designee will do facility rounds 3 times weekly and PRN observing care to ensure staff are following the resident's toileting plan of care per individual resident care plans. Issues identified will be corrected at that time and the DON/designee will review trends in QA&A to ensure plan is implemented, sustained, and evaluated for its effectiveness Allegation of Compliance: December 13, 2016	12/13/2016
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain 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 medical record review, resident and staff interview, and review of the policy and procedure, the facility failed to ensure	F 309	F309 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. 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 section 7305 of the state operations manual. CORRECTIVE ACTION: A) Resident# 2 was given a neurological evaluation by nursing and is with in normal limits for this Resident. Resident# 3 was given a neurological evaluation by nursing and is with in normal limits for this Resident Resident#36was given a neurological evaluation by nursing and is with in normal limits for this Resident Resident#37was given a neurological evaluation by nursing and is with in normal limits for this Resident B) Resident# 28 pain is being evaluated, treated, and documented appropriately Resident #72 no longer resides at the facility	

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F 309	Continued From page 9 neurological assessments were completed as necessary for 4 of 6 sample residents (#2, #3, #36, #37) who experienced falls. Further, the facility failed to ensure effective pain management for 2 of 6 sample residents (#28, #72) with pain. The findings were: With regard to neurological assessments: 1. Review of the 8/14/16 quarterly MDS assessment showed resident #2 had diagnoses that included non-Alzheimer's dementia and required the extensive assistance of two staff members for transfers. The following concerns were identified: a. Review of an incident report dated 5/21/16 and timed 8:15 PM revealed "Resident found on floor mat next to bed. Unwitnessed fall." Review of the medical record revealed no documentation of completed neurological assessments. b. Review of an incident report dated 2/18/16 and timed 4 PM revealed "CNA's alerted me to an unwitnessed fall. [The resident] was found on the floor by [the resident's] bed in low position call light within reach. [The resident] was on [his/her] left side, bleeding from the left side of [the resident's] head. The resident was taken, by ambulance, to the emergency room at 4:30 PM and returned to the facility at 7:45 PM the same day. Review of a nurse's note dated 2/18/16 and timed 10:30 PM revealed "Neuro's [neurological assessments] started upon Res [resident] return from ER." Review of the medical record revealed no documentation of completed neurological assessments. c. Review of an incident report dated 10/8/16 and timed 7:45 AM revealed "Resident was leaning to right in wc [wheelchair]. Was straightened up by staff, but cont [continued] to	F 309	IDENTIFICATION A) Beginning 12/1/ 2016, The DON/Designee reviewed the last 30 days of resident's falls to identify other residents who may not have had a neurological exam per facility policy. For those residents identified a neurological evaluation will be conducted by nursing and documented. Any issues identified will be addressed at that time. B) Beginning 12/1/2016, an assessment of current residents' pain status will be completed by the DON/Designee utilizing the "Pain Review Tool", to ensure pain is managed and to ensure that no other residents have been affected by the alleged deficient practice. The resident's current pain management regimen will be evaluated for its effectiveness and Care plans will be reviewed and updated by the DON/Designee at that time if indicated SYSTEMIC CHANGES A) License Nurses are to complete initial fall evaluation of pain on all new admissions, current residents with new onset of pain and those residents identified by for pain through the RIA process. The Pain Review tool will be completed quarterly, annually, and with significant changes in status. The DON will in-service RN's and LPN's currently employed with facility on the facility's Pain Management System on or before date of compliance specifically ensuring that residents are assessed every shift for pain and it is appropriately documented, and ensuring effectiveness of prn pain medications are documented. PRN and licensed staff on leave will be re-educated upon return to work.	12/13/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING _____ B. WING _____	11/16/2016

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F 309	Continued From page 10 lean to rt [right]. Staff walked by et [and] found resident on floor in front of dresser." The incident was documented as being an un-witnessed fall. Review of the medical record revealed no documentation of completed neurological assessment. d. Interview on 11/15/16 at 1:30 PM with LPN #2 confirmed documentation of the neurological assessments was not available. 2. Review of the 8/8/16 quarterly MDS assessment showed resident #3 had diagnoses that included cerebral palsy and required the extensive assistance of two staff members for transfers. The following concerns were identified: a. Review of an incident report dated 8/11/16 and timed 1 AM showed "Found on floors [with] bed in low position and fall matt [sic] in place. Found in supine position on floor sitting matt [sic]. Placed in w/c [wheelchair] by staff using hoyer lift and brought out to nurses station." The incident was documented as being an un-witnessed fall. Review of the medical record revealed no documentation of completed neurological assessments. b. Review of an incident report dated 8/16/16 and timed 5:30 AM showed "Found lying on tile in prone position awake and delusional. Resident not moved [no] visible bleeding." The incident was documented as an un-witnessed fall. The resident was taken, by ambulance, to the emergency room at 5:45 AM and returned to the facility at 10 AM the same day. Review of the medical record revealed no documentation of completed neurological assessments. c. Review of an incident report dated 9/14/16 and timed 5:30 PM showed "Res [resident] had been in w/c [wheelchair] and was found on floor under w/c [no] injuries noted.	F 309	B) A licensed nurse will evaluate the resident immediately when the fall has occurred. The resident must not be moved until the review is completed, unless there is an immediate safety concern. The review will include but not limited to: Position of resident bleeding, swelling, bruising, redness of skin Pain symptoms (verbal/nonverbal) Vital signs including, if the fall was un-witnessed or the resident sustained a head injury, a neurological exam per facility policy. The DON will in-service RN's and LPN's currently employed with facility on the facility's Neurological exam on or before date of compliance. Specifically ensuring that residents are monitored per facility policy and the neurological exam is appropriately documented. PRN and licensed staff on leave will be re-educated upon return to work. MONITORING A) The DON/Designee will complete audits of Pain management documentation 3 times a week for accuracy and completeness, including reviewing medication administration records for frequency of prn medications and to ensure Resident's pain regimen is effective. Licensed nurses will be re-in-serviced/counseled when documentation requirements are not consistently completed. The IDT will complete quarterly audits of residents MDS, Care Plans and assessment tools, including the quarterly pain assessment tool, to ensure compliance. The DON/Designee will trend reviews and present trends in the Facility's QAPI committee to ensure that this POC is implemented, effective and sustained. B) The DON/Designee will complete audits of Neurological exam documentation after all un-witnessed falls and falls with any head injury for accuracy and completeness. Licensed nurses will be re-in-serviced/counseled when documentation requirements are not consistently completed. The DON/Designee will trend reviews and present trends in the Facility's QAPI committee to ensure that this POC is implemented, effective and sustained.	12/13/2016

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F 309	Continued From page 11 Hoyer used to get res [up] res into bed." The incident was documented as an un-witnessed fall. Review of the medical record revealed no documentation of completed neurological assessments. d. Interview on 11/15/16 at 2:20 PM with LPN #2 confirmed documentation of the neurological assessments was not available. 3. Review of a "SBAR Communication Form" dated 8/12/16 showed resident #36 had a fall at 2 PM. The resident "vomited" after hitting his/her head and was sent to the emergency room for evaluation. Neurological assessments were performed at 15 minute intervals between 2 PM and 2:45 PM. After returning from the emergency room, the resident had a documented neurological assessment at 11:30 PM and another that was timed "AM." There was no evidence the neurological assessments were continued. 4. Review of "Interdisciplinary Progress Notes" showed resident #37 had unwitnessed falls on 7/26/16 and 7/29/16. Further review showed no evidence that neurological checks were completed for either fall. 5. Interview with the DON on 11/16/16 at 12:32 PM revealed the facility should have completed neurological assessments for resident #37's falls; however, they were not able to find evidence the the assessments were completed. Further, the DON revealed the facility did not follow the facility policy related to neurological assessments with the falls for resident #2, #3, #36, or #37. 6. Review of the policy and procedure titled "Fall Management" dated 10/1/11 showed "...Post Fall	F 309		12/13/2016

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F 309	Continued From page 12 A licensed nurse will evaluate the resident immediately when the fall has occurred. The resident must not be moved until the review is completed, unless there is an immediate safety concern. The review will include but not limited to:...If head injury present or suspected...The resident will be monitored, including vital signs, pupil reactions, nausea/vomiting (If a head injury post fall): Every 15 minutes x [times] 4, then Every 2 hours X 3, then Every shift x 3..." With regard to effective pain management: 7. Review of the admission pain assessment dated 11/10/16 showed resident #28 had sharp/throbbing pain in his/her toes on the left foot. Interview with the resident on 11/15/16 at 3:45 PM revealed a fall at home had resulted in a fracture to his/her left leg and surgery had been done to repair the leg. The resident complained of pain in this leg and stated it hurt often. The resident further stated elevating the leg and medication were what helped with the pain. The following concerns were identified: a. Review of the November 2016 MAR showed a pain assessment was to be completed every shift (AM and at bed time). From 11/10/16 to 11/15/16 there were 4 shifts where nothing was documented. b. The November 2016 MAR further showed the resident had an order for Tylenol 650 mg to be given every 6 hours as needed for pain or fever. From 11/10/16 to 11/15/16 the resident received the medication 13 times. The nurses' notes failed to show if the medication was effective in treating the pain for 11 of 13 administrations. There were 9 times when the medication was administered and no pain rating was documented. On 11/15/16 at 8 AM the note	F 309		12/13/2016

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F 309	Continued From page 13 showed the medication was administered for "ankle pain 7/10," the next note on 11/15/16 at 12 PM showed "not much relief cont [continue] pain," On 11/15/16 at 4 PM the note showed the medication was administered for left ankle pain at 5/10. There were no other notes to show how the resident's unrelieved pain was addressed at 12 PM. c. Review of the interim care plan showed pain was not addressed. The care plan had two areas completed on 11/10/16 that related to cardiovascular needs and falls. d. Interview with the DON on 11/16/16 at 12:46 PM verified the notes related to the resident's pain were incomplete, and the care plan related to pain was not developed. 8. Review of the medical record for resident #72 showed an 11/5/16 physician's order for Percocet (an opiod pain medication) 5/325 milligrams, 1 or 2 pills every 4 to 6 hours as needed. Further review revealed this pain medication was prescribed after the resident sustained a fractured arm. Review of the November 2016 physician's orders showed Roxinol (an opiod pain medication) .25 mg every 2 hours as needed for pain/air hunger was ordered on 11/12/16 after the resident fractured his/her leg/hip. Review of the care plan showed interventions for pain included administer medications as ordered, and perform a pain assessment every shift according to the policy. Review of policy CL-Nur-1201, revised 5/5/09, and titled "Pain Risk Review and Management Program," showed staff were directed to document non-pharmacological approaches and medication/pain scale effectiveness on the resident's MAR or facility specific pain flow record. The following concerns were identified:	F 309		12/13/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 14 a. Review of the November 2016 MAR showed Percocet was administered on 11/6/16, 11/7/16, 11/11/16, 11/12/16, and 11/13/16. Further review revealed documentation of non-pharmacological approaches and the effectiveness of the pain medication was lacking. b. Review of the narcotics records showed the resident received Roxinol one time on 11/12/16, four times on 11/13/16, and one time on 11/14/16. Further review revealed documentation of non-pharmacological approaches and the effectiveness of the pain medication was lacking. c. Interviews on 11/15/16 with RN #1 at 11:30 AM and LPN #1 at 11:40 AM revealed staff should document non-pharmacological attempts, and complete assessments for pain and effectiveness. During the interviews both verified staff had not done this consistently for resident #72.	F 309	F315 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. 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 section 7305 of the state operations manual.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review,	F 315		12/13/2016

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F 315	Continued From page 15 and staff interview, the facility failed to provide services to maintain normal bladder function for 1 of 6 sample residents (#64) with urinary incontinence. The findings were: Review of the 10/23/16 annual MDS assessment showed resident #64 had moderate cognitive impairment, required extensive assistance for toileting, and was frequently incontinent of bladder. Review of the resident's care plan for incontinence, updated 10/28/16, showed approaches that included instructions for staff to toilet/check/change the resident upon rising in the morning, before and after meals, at bedtime and on rounds at night. The following concerns were identified: a. Continuous observation on 11/14/16 beginning at 11:25 AM showed the resident was seated in a wheelchair at the nurse's desk. At 12:10 AM CNA #1 wheeled the resident to the dining room for lunch without asking if the resident needed to use the toilet or offering toileting. b. At 12:55 PM, the resident self-propelled to the activity room. None of the staff in the dining room asked if the resident needed to use the toilet or offered toileting assistance before s/he departed. c. At 2 PM, activity assistant #1 wheeled the resident from the activity room to his/her room. The resident remained in the room until 2:20 PM when s/he self-propelled to the nurse's desk. At 2:25 PM, the resident returned to his/her room. At 2:30 PM (over 3 hours since the resident was first observed), while passing ice water, CNA #3 responded to resident's request for assistance with personal hygiene care and toileting. The resident was observed urinating in the toilet. Interview with the CNA at that time confirmed the	F 315	1) Corrective action: Resident #64 is assisted with toileting per her plan of care. The resident is provided timely incontinent care if needed. 2) Identification: Residents that require assistance with toileting at risk. Facility will ensure toileting and/ or incontinence care needs are addressed. Care plans will be reviewed/ revised as needed. 3) Systemic changes: Upon admission residents are assessed for incontinence/ toileting needs utilizing the data collection tool. Residents will be assessed continually through the RAI process. When a resident is identified as incontinent he/ she will be evaluated by a licensed nurse and the nurse will develop a care plan that will include individualized approaches to address the resident's toileting needs. The IDT will update the plan of care and communicate to the nursing staff the suggested toileting plan/ incontinent care plan. On or before the date of alleged compliance, the SDC/Designee will inservice the nursing staff on ensuring residents are toileted timely per the individualized plan of care. PRN and staff members on leave of absence will be in-serviced before returning to work.	12/13/2016

16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 315	Continued From page 16 resident's incontinence brief was wet, and further revealed the resident was unable to perform toileting and incontinence care without staff assistance. The CNA also stated the resident had a hard time "holding it". d. During an interview on 11/16/16 at 3 PM, the DON stated staff re-education was needed regarding following the care plan and offering toileting assistance.	F 315	4) Monitoring: The DON/Designee will do Quality of Care rounds 3 times weekly and prn to ensure residents who are in need of assistance with toileting and/ or are incontinent of bladder receive appropriate treatment and services as indicated. Further monitoring will include review resident council concerns and resident grievances regarding timely toileting. Issues identified will be reviewed in QA&A to ensure plan has been implemented, sustained and evaluated for its effectiveness.	
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 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure hand washing techniques, cleanliness and labeling practices met the food safety and sanitation requirements in 1 of 1 kitchens. The findings were: 1. Observation on 11/14/16 at 10:15 AM and 11/15/16 at 4:36 PM showed the thawed health shakes stored in the refrigerator were not labeled with a date to show when they were to be discarded. The instructions printed on the cartons showed they were to be used within 14 days once thawed. Interview with the dietary manager on	F 371	5) Date of alleged compliance December 13, 2016	12/13/2016

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F 371	Continued From page 17 11/15/16 at 10:55 AM verified the shakes needed to be labeled with a discard date. According to Food Code 2013, U.S. Public Health Service: 3-501.17 "... (B) Except as specified in ¶¶ (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in ¶ (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety." 2. Observation on 11/15/16 at 4:55 PM showed cook #1 wore gloves and with gloved hands handled the walk-in refrigerator door to retrieve chilled dinner plates. The cook failed to remove the gloves and wash his hands prior to getting clean utensils out of a bin and placing them into the food on the steam table. According to Food Code 2013, U.S. Public Health Service, 2-301.14 When to Wash: FOOD EMPLOYEES shall clean their hands and exposed portions of their arms... "(E) After handling soiled EQUIPMENT or UTENSILS...(H)	F 371	F371 It is the policy of Laramie Care Center to provide a clean and sanitary environment for the preparation of meals for our residents. CORRECTIVE ACTION: 1. Thawed health shakes stored in refrigerator without labeled date to show when they should be discarded were discarded by dietary staff. 2. Cook #1 was re-educated on hand washing protocols by Dietary Manager. 3. A. The outside of the two ovens including the handles were cleaned of sticky food residue. B. the 2 blenders located on the food preparation table near the service line with dried –on food residue on the bases, operation switches and the plugs were discarded as they were not being used. C. the fans and ceiling around the fans inside the walk-in refrigerator were cleaned of black dust by dietary staff.	12/13/2016

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F 371	Continued From page 18 Before donning gloves for working with FOOD; and (I) After engaging in other activities that contaminate the hands..." 3. Observation on 11/14/16 at 10:15 AM and 11/15/16 at 4:36 PM showed the following areas in the kitchen in need of cleaning: a. The outside of the two ovens including the handles were soiled with sticky food residue. b. The 2 blenders located on the food preparation table near the service line had dried-on food residue on the bases, operation switches, and the plugs. c. The fans and ceiling around the fans inside the walk-in refrigerator had accumulated black dust. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 4. Interview with the dietary manager on 11/15/16 at 10:55 AM verified the lack of hand hygiene and the cleanliness issues.	F 371	IDENTIFICATION: Residents that reside at Laramie are at risk SYSTEMIC CHANGES On or before the allegation of compliance the Dietary staffs were instructed on proper cleaning schedules, techniques to ensure a clean and sanitary environment for the preparation of meals for our residents by Dietary Manager/Designee. Training included proper hand hygiene when preparing and serving food. Prepare ~~Proper~~ to the allegation of compliance the dietary staffs were instructed to label thawed health shakes with a discard. The Dietary Manager will continue to conduct rounds of the kitchen to ensure proper compliance with policies and procedures and they pertain to sanitation. The results of these audits will be given to Administrator for review. MONITORING The NHA/Designee will continue rounds of the kitchen. The results of these rounds will be given to the Dietary Manager for follow up. Staff will continue to be in-serviced on cleanliness and proper preparation of food. The results of the rounds will be reviewed and discussed during monthly QAPI meetings. If any trends are noted, a plan of action will be developed at that time. 5. Date of compliance December 13, 2016	JY 12/30/16 12/13/2016
F 467 SS=E	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	F 467		

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F 467	Continued From page 19 facility failed to ensure the ventilation system was working in 4 of 9 hallways (South Spruce, Oak, Cedar, North Birch). The findings were: Periodically on 11/14/16, 11/15/16, and 11/16/16, strong unpleasant odors were noted on the South Spruce hallway. On 11/16/16 between 10:50 AM and 11:30 AM the surveyor performed a tissue test on several bathroom ventilation openings and notified the maintenance supervisor when the following resident rooms failed the test: a. Room #31, #35, and #40 on South Spruce hallway. b. Room #52 and #54 on Oak hallway. c. Room #61 on Cedar hallway. d. Room #70 on North Birch hallway. Interview with the maintenance director on 11/16/16 at 4:15 PM confirmed the vents were not working correctly. Further, it was revealed contractors had worked on the ventilation system a week prior; however, he did not verify their work.	F 467	F467 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. 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 section 7305 of the state operations manual. Corrective Action A. The ventilation in the bathroom 31 will be repaired on or before date of compliance. The ventilation in the bathroom 35 was repaired on or before date of compliance. The ventilation in the bathroom 40 was repaired on or before date of compliance. B. Ventilation in rooms #52 and #54 on Oak hallway will be repaired before or on the date of compliance. C. Ventilation #61 on Cedar hallway will be repaired before or on the date of compliance. D. Ventilation in room #70 on North Birch hallway will be repaired on or before the date of compliance. The Maintenance Director/designee completed full facility rounds on 12/01/2016; to identify other room/bathrooms where the ventilation was not functioning. No issues were noted.	12/13/2016
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State;	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535043	A. BUILDING _____ B. WING _____	11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 20 and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the medical records were complete and accurate for 4 of 15 sample residents (#36, #37, #72, #73). The findings were: 1. Review of the September 2016 MAR showed resident #73 had an order dated 9/12/16 for Roxinol (an opiod pain medication) 20 mg/ml 0.25 ml (5 mg) sublingual every 4 hours as needed for pain. Review of the October 2016 MAR showed the order for Roxinol remained the same. The following concerns were identified with the accuracy of documentation: a. According to the September MAR the resident was administered the medication 5 times. Review of nurses' notes for these administrations showed there were notes for 3 of the 5 and the reason for administration was for dyspnea (shortness of breath). Review of the narcotic medication record showed the resident received the Roxinol 13 times from 9/17/16 to 9/30/16. b. According to the October 2016 MAR the resident did not receive the PRN Roxinol at any time. However, review of the narcotic mediation record showed the resident received the medication 3 times from 10/1/16 to 10/3/16. Review of nurses' notes showed there was no reason documented for the medication administrations, or whether the medication was effective.	F 514	Systemic changes The facility will ensure that measures and/or systemic changes put into place will include but not limited to providing a safe, functional and comfortable environment for residents. On or before date of compliance the Administrator/designee provided in-service education and training to the facility maintenance staff regarding ensuring rooms/bathrooms have functioning ventilation. Monitoring The Maintenance Director/designee will monitor compliance via the facility's preventive maintenance program monthly for the next 3 months and as needed thereafter until substantial compliance has been met. Rounds/observations will be conducted monthly. Results through these reviews will be tracked/trended for any issues. Issues identified will be reviewed in QA&A for process improvement to ensure the system is maintained and evaluated for its effectiveness. Compliance on December 13, 2016 F514 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. 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 section 7305 of the state operations manual.	12/13/2016

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F 514	Continued From page 21 2. Review of the November 2016 physician's orders for resident #72 showed Roxinol .25 mg every 2 hours as needed for pain/air hunger was ordered on 11/12/16. Review of the narcotics records showed the resident received Roxinol (pain medication) one time on 11/12/16, four times on 11/13/16, and one time on 11/14/16. Review of the November 2016 MAR showed the Roxinol administrations were not documented on the MAR. Review of nursing notes showed no documentation or assessment regarding the Roxinol. Interview with the DON on 11/16/16 at 11:55 AM revealed the Roxinol should have been documented on the MAR and she did not know why it had not been done. 3. Review of the October 2016 and November 2016 MAR showed resident #36 had an order for pain checks to be performed twice daily. The order showed to use "0-10" pain scale. Further review showed no "HS" [hour of sleep] pain score documented 17 times from 10/1/16 to 10/31/16 and 10 times from 11/1/16 to 11/15/16. 4. Review of the October 2016 and November 2016 MAR showed resident #37 had an order for pain checks to be performed twice daily. The order showed to use "0-10" pain scale. Further review showed no "HS" pain score documented 18 times from 10/1/16 to 10/31/16 and 10 times from 11/1/16 to 11/15/16. 5. Interview with the DON on 11/16/16 at 2:38 PM verified the documentation was lacking and inconsistent related to the medication administration and the pain assessments.	F 514	Systemic changes: On or before the allegation of compliance the DON/Designee will in-service Licensed nurses on maintaining clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized including accurate documentation of pain medications, specifically ensuring that the nurses document effectiveness of prn pain medication and, and pain is evaluated and documented each shift accurately per facility policy . PRN and staff on leave will be re-educated upon return to work. The DON/designee will provide follow up with the appropriate caregivers on identified problems, as deemed necessary. Monitoring: DON/Designee will monitor through review of medication records 3 times weekly and prn. The identified issues will be tracked and trended and results will be included in the DON's/designee's monthly QA and A report to assure that correction is implemented, achieved, sustained and evaluated for its effectiveness. The DON will be responsible for follow up on identified problems/trends. Date of compliance: December 13, 2016	12/13/2016