STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535013	A. BUILDING _____ B. WING _____	C 12/08/2016

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

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 12/4/16 through 12/8/16. Complaints reviewed in the course of this survey were complaint intake WY000002314, WY000002318, WY000002319, WY000002320, WY000002323, and WY000002327. 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 PPE: Personal Protective Equipment BIMS: Brief Interview for Mental Status Less commonly used abbreviations will be annotated in each deficiency.	F 000	Preparation and execution of the response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the state and federal law. For the purposes of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual	
F 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this	F 166	F166 Right to Prompt Efforts to Resolve Grievances **1. Corrective Action** Unresolved clothing grievances for Resident #38 and #91 that were identified on 12/08/2016 were resolved before 12/30/2016. **2. ID of Others** The Social Services Director or Designee will review the grievance log for any unresolved grievances to	12/30/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 12/31/2016

2/14/17 11:01 AM spoke to Lea Lowe administrator. Plan of Correction accepted ~~agreed upon Changes~~

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F 166	Continued From page 1 paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;	F 166	ensure grievances are resolved timely before 12/30/2016. **3. Systemic Change** The Social Services Director or Designee will complete a weekly audit of the grievance log to ensure grievances are resolved timely. The Director of Nursing or Designee will educate the interdisciplinary team members whom are responsible for resolving grievances to ensure the grievance is resolved timely before 12/30/2016. **4. Monitoring** The Social Services Director or Designee will report results of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as determined by the committee.	

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F 166	Continued From page 2 (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family, and staff interview, review of resident grievances, and review of policy and procedures, the facility failed to ensure grievances were resolved for 2 of 4	F 166		

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F 166	Continued From page 3 sample residents (#38, #91) who were missing clothing. The findings were: 1. Interview with resident #38 on 12/4/16 at 6:06 PM revealed s/he was missing some clothing items and was down to his/her last items. Further, the resident revealed s/he had reported this to the facility and felt it took them a long time to return items. The following concerns were identified: a. Observation on 12/5/16 at 9 AM showed the resident had 4 pairs of pants, 3 shirts, and 1 pair of socks in his/her room. Interview with the resident at that time revealed the facility had not returned all of his/her missing items and some of the items that were returned after the resident filed a grievance belonged to another resident with a similar name. b. Review of a grievance form dated 11/29/16 showed the resident filed the grievance on 11/29/16. The grievance showed the resident reported missing quarter socks, long socks, possibly pants, and shirts. The items were labeled when the resident was admitted. The "investigation/action" section showed "found multiple items will continue to look for additional items" and "items were returned to resident." The "resolution of grievance" section showed the grievance was resolved on 11/30/16 at 3:30 PM; however, a note at the top of the grievance showed laundry and housekeeping received the grievance on 12/2/16. c. Observation on 12/8/16 at 1:41 PM showed the resident had 2 pairs of pants, 2 shirts, and no socks in the room. Interview with the resident at that time revealed the facility had not delivered any items since the room was last observed on 12/5/16, more than 72 hours earlier. d. Review of the medical record showed the facility failed to complete an inventory of the	F 166		

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F 166	Continued From page 4 resident's belongings at the time of admission on 11/8/16. 2. Review of a grievance form dated 11/14/16 revealed a grievance filed by a family member of resident #91 which concerned the loss of personal clothing that had not been returned from the laundry. The resident was admitted on 10/6/16. The following concerns were identified: a. Review of the resident's admission inventory list included 1 coat, 1 hat, 1 pair of shoes, 1 pair of slippers, 6 shirts, 6 sweaters, 4 jeans, 7 pairs of sweat pants, 4 pairs of compression stockings, and 4 braces. b. Observation of the resident's closet on 12/6/16 at 3 PM showed 1 coat, 1 hat, 1 pair of slippers, 3 pairs of sweat pants, and 11 long sleeve shirts. The dresser drawers contained the stockings and braces. Observation of the resident at the same time showed s/he was wearing sweat pants, shoes, and a long-sleeved shirt. c. Interview with a family member on 12/7/16 at 4:50 PM confirmed the loss of the clothing items. The family member stated "I have not seen 4 pairs of jeans since [the resident] moved in in October." She stated she was told that there was a whole pile of laundry in the laundry area and the facility was trying to hire people to go through it and sort it out. She stated she was told this "approximately 2 weeks ago." d. The facility was unable to provide any documentation of efforts to resolve the 11/14/16 grievance. 3. Interview with the administrator on 12/8/16 at 1:34 PM revealed there was a 72-hour time frame for items to be returned from the laundry. Further, she did not feel that missing items were "out of hand."	F 166		

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F 166	Continued From page 5 4. Review of the facility "Grievance Policy" last updated April 2015 revealed: "...5. Grievances are resolved immediately, when possible, by the individual receiving the grievance. 6. When immediate resolution is not possible the grievance is routed to Social Services or designee within 24 hours. The individual receiving the grievance fills out a Grievance Form...8. Social Services or designee routes the Grievance Form to the appropriate department manager, who reviews the grievance, responds within 48 hours, and returns the Grievance Form to Social Services or designee. 9. Social Services or designee logs Grievance Forms on the Grievance Log. 10. The ED reviews the Grievance Log at the Daily Stand-Up Meeting. 11. Social Services or designee analyzes grievances monthly for tracking and trending. Identifiable trends are addressed through the QAPI Committee..."	F 166		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 observations, staff interview, and medical record review the facility failed to provide the care according to the care plan for 1 of 10 sample residents (#56) with dementia. The findings were:	F 282	F282 Services by Qualified Persons/Per Care Plan **1. Corrective Action** Care plan for Resident #56 was updated before 12/30/2016. **2. ID of Others** The Director of Nursing or Designee will audit residents identified for risk of impaired skin integrity before 12/30/2016 to ensure residents identified are offloaded and repositioned frequently.	12/30/16

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F 282	Continued From page 6 1. Review of the 9/19/16 significant change MDS assessment for resident #56 showed diagnoses which included Alzheimer's dementia, Non-Alzheimer's dementia, and Stage 2 pressure ulcer; left and right buttock. The resident had a BIMS (Brief Interview for Mental Status) of 4/15 (severe impairment), and 2 unhealed Stage 2 pressure ulcers. The resident was frequently incontinent of urine and bowel and needed the extensive assist of 1 staff member for toileting and personal hygiene. The following concerns were identified: a. Continuous observation on 12/6/16 from 9:18 AM until 12:45 PM (approximately 3 hours and 30 minutes) showed the resident was seated in a chair in the dining room. At no time was the resident approached and taken to the bathroom. At 9:45 AM s/he stood up to have his/her chair moved to participate in an activity. At the end of the activity the resident was pushed back to the dining table in his/her chair without standing up. The resident then sat in his/her chair for 3 hours. b. Review of the incontinence section of the care plan dated 10/3/16 revealed "nursing to provide extensive assist with toilet use as needed" and "check for incontinence; clean and dry skin if wet or soiled." c. Review of the skin integrity section of the care plan dated 10/3/16 revealed "Encourage and assist resident to offload as needed." d. Interview with LPN #1 on 12/8/16 at 2:15 PM revealed the expectation that the resident should be toileted "every two hours while awake" and "offload every couple hours."	F 282	**3. Systemic Change** The Director of Nursing or Designee will educate nursing staff before 12/30/2016 to ensure residents are repositioned and skin is offloaded frequently. The Director of Nursing or Designee will complete a random audit of residents identified for risk of impaired skin integrity weekly to ensure residents identified are offloaded and repositioned frequently. **4. Monitoring** The Director of Nursing or Designee will report results of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as determined by the committee.	
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425	F425 Pharmaceutical Services-Accurate Procedures, RPH	12/30/16

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F 425	Continued From page 7 (a) Procedures. 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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who– (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure medications were received in a timely manner for 1 of 1 sample resident (#107) with physician orders for antibiotic therapy. The findings were: Review of the medical record for resident #107 showed an undated telephone order timed 2:30 PM for Macrobid (an antibiotic) 100 mg (milligrams) po (by mouth) q (every) day x (times) 7 days. The order was marked as "STAT" (to be started immediately). The following concerns were identified: a. Review of a nurse's note dated 12/1/16 and timed "6 PM to 6 AM" showed the resident's Macrobid arrived at 1 AM; however, the first dose would not be administered until 8 AM. b. Interview with the DON and regional nurse on 12/8/16 at 11:36 AM revealed the facility usually had Macrobid in the emergency kit; however, at the time of the order, it was not available and they had to get it from the pharmacy. The pharmacy did not send the medication from a local back-up pharmacy to begin treatment even though the order said	F 425	**1. Corrective Action** Resident #107 was discharged, return anticipated and had a negative lab result on 12/02/2016. **2. ID of Others** The Director of Nursing or Designee will complete an audit of Antibiotic orders to ensure medications are administered timely before 12/30/2016. **3. Systemic Change** The Director of Nursing or Designee will educate nursing staff before 12/30/2016 to ensure Antibiotic orders are administered timely. The Director of Nursing or Designee will complete a daily audit for six (6) weeks then weekly of Antibiotic orders to ensure medications are administered timely before 12/30/2016. **4. Monitoring** The Director of Nursing or Designee will report results of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as determined by the committee.	

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F 425	Continued From page 8 "STAT." The DON and regional nurse also confirmed the medication was received on 12/2/16 at 1 AM and the first dose was not administered until 8 AM on that same day.	F 425	F441 Infection Control Prevent Spread, Linens **Corrective Action**	
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 441	Resident #51, #56, #67, #26,#15, #16, #35 and #36 were placed into isolation for investigation and assessment of illness suspected, physician recommendations, and reviewed for chronic underlying conditions that can be contributing factors, if applicable before 12/30/2016 with reflected documentation in support of these interventions. Resident #14 and #21 were not placed into isolation as there last noted symptom was on 12/04/2016. The Director of Nursing or Designee conducted rounds on all units for each isolation room immediately on 12/07/2016 to ensure appropriate PPE usage, cleaning, review of documentation, and transmission-based precaution interventions were in place. The Executive Director or Designee sought counsel from company infection control preventionist to	12/30/16

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F 441	Continued From page 9 (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family, and staff interview, medical record review, and policy and procedure review, the facility failed to implement an effective infection control program that ensured identification, investigation, intervention, and containment of infections. The census was	F 441	review policies and procedures, checklists and department education before 12/30/2016. The Staff Development Coordinator or Designee obtained two (2) stool samples which were submitted to the Wyoming State Epidemiology, the negative results for Noro and other bacterial and viral infectious agents were received before 12/30/2016. The Director of Nursing or Designee educated nursing, dietary, activities and housekeeping staff regarding transmission based precautions, PPE, PPE Storage, use, cleaning requirements for potential infections, hand hygiene and C-Diff/ Noro suspected precautions, dietary infection control guidelines and symptom free requirement for staff every shift for 24 hours before 12/30/2016. **ID of Others** The Director of Nursing or Designee will complete an audit for new symptoms of nausea, vomit, and diarrhea through medical record review, staff and resident interviews to ensure residents presenting with	

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F 441	Continued From page 10 105. Further, the facility failed to ensure isolation precautions were followed during 3 of 27 observations of care (involving residents #51, #56) for residents on contact precautions. The findings were: 1. Observation during the initial tour of the building on 12/4/16 at 5:10 PM showed resident #67 was in his/her bed with a family member present. Interview with the family member, at that time, revealed the resident had been vomiting and had diarrhea since 12/3/16. Observation on 12/4/16 at that time showed there was no PPE or signage on or near the resident's door to indicate the resident had been placed on any precautions. Review of a nurse's note dated 12/3/16 and timed 9:45 PM showed "[the] resident had emesis and diarrhea for one hour during the lunch time, and again for an hour this evening from 1750-1850 [5:50-6:50 PM]. " 2. Observation during the initial tour of the building on 12/4/16 at 5:18 PM showed resident #26 was in bed during the evening meal. During observation of the 2nd floor nurse-to-nurse report on 12/4/16 at 5:51 PM, the off-going nurse revealed the resident remained in his/her room related to episodes of "emesis [vomiting]." Observation of the resident's room on 12/4/16 at 5:51 PM showed no evidence that isolation precautions had been implemented. Review of the medical record for the resident showed no evidence of assessment or monitoring of nausea or vomiting. Observation on 12/5/16 at 7:56 AM showed the resident was in the 2nd floor dining room with other residents. Further, no precautions had been implemented related to the resident's symptoms.	F 441	symptoms are placed into isolation for type of illness suspected, physician recommendations, and reviewed for chronic underlying conditions that can be contributing factors, if applicable. A Line Listing of all residents/ staff symptomatic was initiated and maintained for tracking and monitoring for continued and removal of isolation precautions before 12/30/2016. The Director of Nursing or Designee conducted rounds on all units for each isolation room every hour before 12/30/2016 for 24 hours to ensure access and availability and use of PPE for all current transmission based precautions rooms. The Environmental Services Director or Designee monitored housekeeping staff on each isolation room, three times per day before 12/30/2016 for 24 hours to ensure appropriate cleaning technique when cleaning areas identified with potential common source of infection.	

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F 441	Continued From page 11 3. Interview with LPN #2 on 12/5/16 at 8:30 AM revealed 7 residents (#14, #15, #16, #21, #26, #35, #36) on the 2nd floor had nausea, vomiting, and/or diarrhea over the weekend. Further, the symptoms "came and went in a day" and the facility kept the residents in their rooms for the day. 4. Review of the medical records for residents #14, #15, #16, #21, #26, #35, and #36 on 12/5/16 showed no evidence the residents had been assessed or monitored for nausea, vomiting, and/or diarrhea. 5. Interview with resident #36 on 12/6/16 at 9:09 AM revealed s/he had been "sick for 3 or 4" days with diarrhea and vomiting. Review of the 12/1/16 quarterly MDS assessment showed the resident was cognitively intact with a BIMS (Brief Interview of Mental Status) score of 15/15. 6. Interview with the infection preventionist on 12/5/16 at 10:55 AM revealed she was not aware of any residents having symptoms that might have been related to gastrointestinal illness. Further, she revealed if residents were having any nausea, vomiting, or diarrhea it should have been communicated verbally to the nurse on call and/or written on the 24-hour report. Residents who had gastrointestinal symptoms should have been placed on contact precautions until 48 hours after the symptoms had ceased. Continued interview confirmed none of the residents that had been identified by the nurse as having symptoms over the weekend were placed on precautions. 7. Review of the facility policy titled "Surveillance for Infections" published 05/15 showed "Policy	F 441	**Systemic Changes** The Staff Development Coordinator or Designee will validate that the isolation implementation policy and procedure is available on each unit as a reference before 12/30/2016. The Director of Nursing or Designee will educate all staff regarding the proactive identification of a potential outbreak and the course of action to be taken immediately to prevent further potential spread of illness before 12/30/2016. **Monitoring** The Director of Nursing or Designee will complete an audit of signs or symptoms of nausea, vomit or diarrhea daily for six (6) weeks to ensure residents presenting symptoms are placed into isolation for type of illness suspected, physician recommendations, and reviewed for chronic underlying conditions that can be contributing factors, if applicable. As well as, proper usage of PPE including family education in transmission based precaution rooms.	

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	535013	A. BUILDING _____ B. WING _____	C 12/08/2016

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F 441	Continued From page 12 Statement: The Infection Preventionist conducts ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on the potential resident outcome and that may require transmission-based precautions and other preventative interventions. Surveillance of infections: 1.The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and Healthcare-Associated Infections, to permit interventions, and to prevent future infections ...3. Infections that are included in routine surveillance include those with: a. Evidence of transmissibility in a healthcare environment; b. Available processes and procedures that prevent or reduce the spread of infection; c. Clinically significant morbidity or mortality associated with infection (e.g., pneumonia, UTIs, C. difficile); and d. Specific pathogens associated with serious outbreaks. (e.g., invasive streptococcus Group A, acute viral hepatitis, norovirus, scabies, influenza) ...5. Nursing Staff monitor residents for signs and symptoms that may suggest infection, according to current criteria and definitions of infections, and document and report suspected infections to the Infection Preventionist immediately. 6. If a communicable disease outbreak is suspected, the information is communicated to the Director of Nursing Services and Infection Preventionist immediately ..." In regard to appropriate precautions for residents on isolation: 8. Observation on 12/4/16 at 7:15 PM showed resident #56 was on contact precautions for C-diff (Clostridium difficile) and was taken to his/her room by CNA #1. The CNA donned a mask and gloves, but no gown, and took the resident to the	F 441	The Environmental Services Director or Designee will audit isolation rooms daily for six (6) weeks to ensure housekeepers use appropriate cleaning technique when cleaning areas identified with potential common source of infection. The Director of Nursing or Designee will report results of the audits to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as determined by the committee.	

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F 441	Continued From page 13 bathroom. At the same time LPN #3 used hand sanitizer, donned gloves and a mask, but no gown, and entered the room to administer medication. At 7:20 PM the LPN donned a mask and gloves, but no gown, and re-entered the room to administer medication. Interview with CNA #1 on 12/4/16 at 7:35 PM revealed that masks and gloves were to be worn in the bathroom of resident #56 when skin-to-skin contact was anticipated; however, she was not aware that a gown should be worn. Interview with LPN #3 on 12/4/16 at 7:38 PM revealed that masks and gloves were to be worn in the resident's room; however, she was not aware that a gown should be worn. 9. Observation on 12/5/16 at 10:10 AM showed resident #56 was taken to his/her room by CNA #3. The CNA did not don any PPE at this time, went into the resident's bathroom with the resident, then from the bathroom to the resident's closet. CNA #2 came to the door of the resident's room and instructed CNA #3 about the PPE needed for the room. CNA #3 then donned a gown, cap, and gloves and continued to assist the resident. Interview with CNA #3 on 12/5/16 at 10:30 AM revealed she was called in for an unscheduled shift and was not given any instruction on PPE until she was in resident #56's room. Observation on 12/5/16 at 12:32 PM showed resident #56 was taken to his/her room by CNA #3, who donned appropriate PPE; however, after leaving the room soiled items were left in a pink basin on the floor of the resident's bathroom. Observation on 12/5/16 at 12:48 PM showed CNA #3 donned gloves, but no gown, and bagged the contaminated soiled items in a red bag.	F 441		

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F 441	Continued From page 14 10. Interview on 12/7/16 at 11:48 AM with a family member, in the doorway of resident #56's room, revealed no education had been offered in regards to what precautions were needed upon entry into the room. The family member was not wearing any PPE. 11. Interview with resident #51 on 12/8/16 at 1:45 PM showed s/he had witnessed staff bring non-disposable food trays into the room, which was under isolation precautions, and then later remove the trays and place them on the food cart without covering them. Observation at that time showed the resident and his/her roommate had non-disposable food trays in the room. Also at that time CNA #7, without any PPE, came into the room and removed a food tray and placed the tray uncovered on the food cart. Review of the 12/5/16 quarterly MDS assessment showed the resident was cognitively intact with a BIMS score of 15/15. 12. Interview with the infection preventionist on 12/5/16 at 10:55 AM revealed PPE for contact precautions should include gloves, gowns, and masks when providing care to residents. Further, for residents with gastrointestinal symptoms, the PPE should be worn into the resident's room during care or cleaning. 31. Review of the facility Policy and Procedure titled "Initiating Transmission-Based Precautions" published 05/15 revealed a policy statement: "Transmission-Based Precautions are initiated when there is reason to believe that a resident has a communicable infectious disease. Transmission-Based Precautions may include Contact Precautions, Droplet Precautions, or Airborne Precautions."	F 441		

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F 441	Continued From page 15 The procedure was defined as: 1. If a resident is suspected of, or identified as, having a communicable infectious disease, the Charge Nurse or Nursing Supervisor notifies the Infection Preventionist and the resident's Attending Physician for appropriate Transmission-Based Precautions ...4. Transmission-Based Precautions remain in effect until the Attending Physician or Infection Preventionist discontinues them, which occur after pertinent criteria for discontinuation are met. 5. When Transmission-Based Precautions are implemented, the Infection Preventionist or designee: a. Validates protective equipment (i.e., gloves, gowns, masks, etc.) is maintained near the resident's room so that everyone entering the room can access what they need; b. Posts the appropriate notice on the room entrance door and on the front of the resident's chart so that all personnel will be aware of precautions, or be aware that they must first see a nurse to obtain additional information about the situation before entering the room. This Center's process for notification is signage ...f. Explains to the resident (or representative) the reason(s) for the precautions..."	F 441		
F 502 SS=D	483.50(a)(1) ADMINISTRATION (a) Laboratory Services (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and family and staff interview, the facility failed to ensure labs	F 502	F502 Administration **Corrective Action** Received negative lab results for resident #107 before 12/30/2016 **ID of Others** The Director of Nursing or Designee will complete an audit of UA orders to ensure labs were obtained timely before 12/30/2016.	12/30/16

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F 502	Continued From page 16 were obtained in a timely manner for 1 of 1 sample resident (#107) with orders for laboratory testing. The findings were: Review of the medical record for resident #107 showed the resident had a telephone order written on 11/23/16 at 1 PM for the facility to collect a urine specimen for a follow-up urinalysis. The following concerns were identified: a. Review of a lab result dated 11/27/16 showed the specimen was collected on 11/25/16 and found to have "possible contamination" on 11/27/16. b. Review of a lab result dated 12/1/16 showed a new specimen was collected on 11/29/16 and results on 12/1/16 showed the resident was positive for Enterococcus faecalis (a bacterial organism). c. Interview with the DON and regional nurse on 12/8/16 at 11:36 AM confirmed there had been a delay in obtaining the urine specimen and stated it was because the resident took him/herself to the bathroom. d. Interview with a family member on 12/12/16 at 8:15 AM revealed the resident was able to walk to the bathroom without assistance in the past; however, the resident was no longer able to do so. Further, the resident forgot to use his/her call light and, during the last care plan meeting it was decided that a "prompt" toileting plan should be initiated due to concerns over increased urinary tract infections and toileting. e. Review of the quarterly MDS assessment with an assessment reference date of 9/13/16 showed the resident required the extensive physical assistance of one person for transfers and toilet use.	F 502	**Systemic Change** The Director of Nursing or Designee educated nursing staff on UA orders, and the importance of obtaining lab timely before 12/30/2016. The Director of Nursing or Designee will audit UA orders daily for six (6) weeks then weekly to ensure UA orders and labs are obtained timely. **Monitoring** The Director of Nursing or Designee will report the results of the audit to facility quality assurance meeting for 90 days or until substantial compliance has been achieved or sustained or determined by the committee.	
F 514	483.70(i)(1)(5) RES	F 514		12/30/16

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F 514 SS=E	Continued From page 17 RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (I) Sufficient information to identify the resident; (II) A record of the resident's assessments; (III) The comprehensive plan of care and services provided; (IV) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and medical record review, the facility	F 514	F514 Records Complete/Accurate/ Accessible **1. Corrective Action** The Director of Nursing or Designee will educate staff before 12/30/2016 regarding proactive identification of infections or suspected infections and the course of action to be taken, as well as, staff communication to the Staff Development Coordinator on infections or suspected infections. **2. ID of Others** The Director of Nursing or Designee will complete an audit of signs or symptoms of nausea, vomit and or diarrhea utilizing multiple sources to ensure the medical record is accurate before 12/30/2016. **3. Systemic Change** The Director of Nursing or Designee will educate staff before 12/30/2016 regarding proactive identification of infections or suspected infections, the course of action to be taken, appropriate documentation in the medical record, as well as, staff communication to the Staff Development Coordinator or	

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F 514	Continued From page 18 failed to ensure the medical record was accurate and complete for 7 of 34 sample residents (#14, #15, #16, #21, #26, #35, #36) with nausea, vomiting, and/or diarrhea. The findings were: 1. During observation of the 2nd floor nurse-to-nurse report on 12/4/16 at 5:51 PM the off-going nurse revealed resident #26 remained in his/her room related to episodes of emesis. Interview with LPN #2 on 12/5/16 at 8:30 AM revealed 7 residents (#14, #15, #16, #21, #26, #35, #36) on the 2nd floor had nausea, vomiting, and/or diarrhea over the weekend. Further, the symptoms "came and went in a day" and the facility kept the residents in their rooms for the day. The following concerns were identified: a. Interview with the infection preventionist on 12/5/16 at 10:55 AM revealed she was not aware of any residents having symptoms that may have been related to gastrointestinal illness. Further, she revealed if residents were having any nausea, vomiting, or diarrhea it should have been communicated verbally to the nurse on call and/or written on the 24-hour report. b. Interview with the DON on 12/5/16 at 1:06 PM revealed she had reviewed the records of residents #14, #15, #16, #21, #26, #35, #36 and confirmed none of them had documentation of resident illness. c. Interview with resident #36 on 12/6/16 at 9:09 AM revealed s/he had been "sick for 3 or 4" days with diarrhea and vomiting. d. Review of the medical records for residents #14, #15, #16, #21, #26, #35, and #36 on 12/5/16 showed no evidence the residents had been assessed or monitored related to nausea, vomiting, and/or diarrhea.	F 514	designee on infections or suspected infections. The Director of Nursing or Designee will complete a daily audit for six weeks then weekly of signs or symptoms of nausea, vomit and or diarrhea utilizing multiple sources to ensure appropriate documentation in the medical record. **4. Monitoring** The Director of Nursing or Designee will report results of the audit to the facility monthly Quality Assurance Meeting for 90 days or until substantial compliance has been achieved or sustained as determined by the committee.	