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

PRINTED: 01/20/2017
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
	53A051	A. BUILDING _____ B. WING _____	01/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LINCOLN NURSING CENTER	711 ONYX STREET KEMMERER, WY 83101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification and licensure survey was conducted on 1/5/17/28/18 without complaints to survey. Issues cited are part of the 2567. The following common abbreviations are used throughout this document: CAA Care Area Assessment DON Director of Nursing MAR Medication Administration Record MDS Minimum Data Set LPN Licensed Practical Nurse CNA Certified Nurse Aide Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(i) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70	F 164	1. Computer privacy screen protectors have been ordered (have not arrived yet) for the medication cart laptop and the two computers at the nurses station that will be placed to help ensure resident privacy and that HIPPA is being followed. 2. All staff in long term care have received education on our HIPPA policy for South Lincoln Nursing Center yearly. Last HIPPA in-service was on January 17, 2017. 3. We are currently in the process of having an electronic education system that has all of the mandatory in-services that are due by end of April 2017. Staff will be set up with their log-in within the next 2 weeks. 4. Once privacy screens are in place, a QA/QI project will be created for long term care to monitor and track proper use and that we are being compliant with HIPPA regulations. As of 2/1/2017 two of the computer screens have the privacy screen protectors in place. The lap top one was the wrong size, this has been re-ordered and will be placed as soon as it arrives. In the meantime, the nursing staff are minimizing the screen whenever they leave the med cart lap top.	02/08/2017

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

CEO 2/16/17

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: DQAK11 Facility ID: WY0041 If continuation sheet Page 1 of 31

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Healthcare Licensing and Surveys

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F 164	Continued From page 1 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (I) To the individual, or their resident representative where permitted by applicable law; (II) Required by Law; (III) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure confidentiality of medical records, which had the potential to affect all facility residents. The census at the time of the survey was 17. The findings were: 1. Observation on 1/4/17 between 7:01 PM and 7:27 PM showed LPN #2 gathered medications for residents using the computer on the medication cart located at the nurse's station. After preparation, the nurse left the cart unattended to bring the medications to the resident's room. The nurse did not close the medication administration record screen when	F 164		

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F 164	Continued From page 2 delivering the medications, which allowed resident information to be viewed by anyone who passed the unattended medication cart which was located in a public area. 2. Interview on 1/4/17 at 7:55 PM with the nurse verified that she had received training regarding the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which required appropriate safeguards to protect the privacy of personal health information. 3. Interview on 1/5/17 at 2:35 PM with the DON revealed it was the expectation the medication cart and electronic medical records be secured when not in view of the nurse.	F 164		
F 167 SS=B	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual	F 167	1. 2014 and 2016 state survey results are in a black binder outside the staff lounge. They are at wheelchair level, easily accessible to both residents and family. 2. Once 2017 state survey plan of corrections are approved by the state a copy will be placed in the binder with each year labeled under a flip tab, showering the last 3 years with the most recent survey in front. As of today 2/1/17 a copy of the state survey for 2016 has been placed in the survey book along with tabs to divide the years for easier reading. 3) Quarterly the Nurse Manager will check the survey book to ensure the last 3 years of surveys are present and labeled correctly. This will be added to the LTC QA/QI project tracking sheet.	02/05/2017

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F 187	Continued From page 3 to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to publicly display the most current survey results for 2 of 3 days during state surveyor visitation. The findings were: Observation on 1/3/17 at 5:23 PM showed the common area near the nurse's station had a wall-mounted display with a binder which contained survey results and plans of correction. However, the survey results and plan of correction on display were dated 2014, and were not current. Interview on 1/5/17 at 2:35 PM revealed the DON had removed the most current survey results and plan of correction in the prior week in preparation for a staff meeting. She further stated she had not put the paperwork back into the display binder until 1/5/17 in the morning.	F 187		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or	F 225		

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F 225	Continued From page 4 mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities 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. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 225		

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F 225	Continued From page 5 (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 medical record review, incident report review, State Survey Agency incident log review, facility policy and procedure review, and staff interview, the facility failed to ensure 1 of 1 incidents reviewed (#17) which involved an injury of unknown origin was reported to the state survey agency. The findings were: Review of facility incident reports showed an 11/30/16 incident concerning resident #17. The resident was found to have bruises on the right upper arm of unknown origin. Two CNAs (#2, #3) who worked the night shift just before the bruises were discovered were placed on administrative leave pending investigation, and the investigation was completed. Review of the 11/23/16 quarterly MDS assessment showed the resident had a BIMS score of 13 (cognitively intact). However, s/he could not recall any reason for the bruises. The following concerns were identified: a. Review of the incident report showed no evidence the facility reported the incident to the	F 225		

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F 225	Continued From page 6 State Survey Agency as required. b. Review of the State Survey Agency incident log showed no evidence the facility reported the incident. c. Review of the facility policy titled, "Abuse Prohibition" last revised 10/8/09 showed the following definition for injuries of unknown origin: "1. The source of injury was not observed by any person or the source of injury could not be explained by the resident; and 2. The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time." The requirement at Reporting/Response included the following: "Alleged violations will be reported to the Office of Healthcare Licensing and surveys and the Department of Family Services within 24 hours of the allegation." d. Interview with the DON on 1/5/17 at 3:30 PM revealed she believed only allegations that were substantiated were to be reported to the state survey agency. She was unaware that all allegations of abuse were required to be reported within two hours whether or not the allegations were substantiated.	F 225	1. All suspected abuse situations will be: a. Long term care staff will report it to the nurse manager immediately b. Nurse manager will arrive on scene, assess the situation and interview the resident c. Nurse manger will report to the state of Wyoming within 2 hours d. Nurse Manager will meet with staff involved in suspected abuse after notifying the state to determine if administrative leave is needed. @ this time the Nurse Manager will notify Administrator, Human Resource and Risk Manager. Interviews with the staff will be set-up e. Every day the Nurse Manager will send an update to the state regarding where South Lincoln Nursing Center is at with the investigation. f. With final results of the investigation the Nurse Manager will notify the state and have the case closed. 2. Long Term Care will create a QA/QI project to track the number of suspected abuse situations monthly and that they were reported to the state within the 2 hour window that we have been given. This will be monitored monthly.	02/08/2017
F 244 SS=E	483.10(f)(5)(iv)(A)(B) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION (f)(5) The resident has a right to organize and participate in resident groups in the facility. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.	F 244	1. This issue has been discussed with the House Keeping supervisor and a quality assurance plan has been created for tracking and monitoring of the laundry and the issues 2. All residents clothing was relabeled due to their names fading and coming off of some of their clothes. This was done by the C.N.A. staff and laundry staff working together to make it easier to identify who the laundry belongs to. 3) Laundry will ask CNA staff when clothing is not marked to ensure	02/08/2017

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F 244	Continued From page 7 (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and resident council meeting minutes review, the facility failed to act promptly upon the grievances of the resident council for 2 of 2 issues reviewed. The findings were: 1. The following concerns were identified regarding resident laundry: a. Review of resident council minutes dated 10/7/16 showed under old business: "laundry isn't being returned correctly," and under new business: "Laundry is still being mixed up, lost, or taking a long time to return to residents." Resident council minutes dated 11/1/16 showed under old business: "laundry problems," and under new business: "[Resident #1] is missing a new pair of pants again and [Resident #19] still has not received his lost clothing either." Resident council minutes dated 12/6/16 showed under old business: "Laundry problems: white clothes are looking a little dingy and several of the resident's clothes have been shrunk." b. Interview on 1/4/16 at 10:30 AM with resident #16 revealed the resident felt the staff didn't "bring the right clothes back sometimes," and described his/her daughter finding a red article of clothing in the closet that was twice the size of what s/he wears. S/he explained the clothing must have belonged to another resident. c. Interview on 1/4/16 at 12:30 PM with	F 244	a) clothing is marked appropriately b) clothing is delivered to the right resident 4) We will continue to have monthly resident counsel meetings to follow up on any complaints that were made previously and to ensure there are no new complaints.	

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F 244	Continued From page 8 residents during group interview revealed the issues with laundry had not been resolved. d. Interview on 1/5/17 at 2:35 PM with DON revealed she had spoken with laundry staff on 1/4/17 and wasn't sure why clothing was being misplaced. She acknowledged missing laundry was an ongoing problem that had not been corrected. 2. The following concerns were identified regarding staff treatment of residents: a. Interview on 1/4/17 at 12:30 PM with five residents revealed 2 of 5 residents present had concerns about CNA #1. A resident shared that s/he witnessed the CNA being "mean and impatient" with one of the other residents who needed assistance with walking. Another resident stated the CNA was short with her and wouldn't assist her to the bathroom. b. Interview with resident #17 on 1/4/17 at 10 AM revealed that CNA #1 could be short with him/her and other residents, and somewhat rude. c. Review of the December 6, 2016 resident council minutes revealed under old business, "All elders present (#1, #17, #2, #3) did complain about CNA #1's attitude, said she was snappy and short with them." d. Review of the employee personnal record for CNA #1 showed there were no reprimands or incidents discussed. Interview with the DON on 1/5/17 at 3:30 PM showed she had spoken with CNA #1 about attitude with residents and resident concerns. However, she had failed to document the verbal reprimand, and had failed to inform the resident council about action taken to prevent CNA #1 from being rude and short with residents. She also failed to further investigate this issue.	F 244	1. No resident has ever reported to resident counsel or to the Nurse Manager that they have witnessed a staff member being mean to another resident. This is not tolerated nor allowed and is immediately followed up on. 2. One of the residents have a tendency to report staff being mean or rude when she does not get what she waits or is gently reminded that she has gained weight. I have visited with the resident and staff multiple times about this and do not feel that this is an issue. 3. The C.N.A that the resident counsel reported as having issue with her attitude was talked to after resident counsel and this document was faxed to the state office along with all of the other ones. 4. The update regarding the conversation as not documented in the resident counsel notes because they do not need to know personnel issues, Nurse Manager talked with the resident counsel to see if things had improved with this aid and when they stated the issues had resolved then it was not brought up again.	02/08/2017
F 248	483.24(c)(1) ACTIVITIES MEET	F 248		

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F 248 SS=E	Continued From page 9 INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on review of activity calendars, resident interview, and staff interview, the facility failed to provide an activities program to meet the needs of residents. The resident census was 17. The findings were: Interview on 1/3/17 at 4:15 PM with the DON revealed the activity director had been on leave since late September of 2016, and a new activity director had started working on 1/3/17. The DON stated the facility staff had attempted to provide activities in the absence of the activity director, and that she and the social services director formulated monthly activity calendars for staff to follow. The following concerns were identified: 1. Review of the activity calendars for November 2016, December 2016, and January 2017 showed the only activities on weekends were church service on Sundays and "All Day-Leisure Day" on Saturdays. One exception was "Spaghetti Dinner" on Saturday, December 31st. In addition, no weekday activities were listed on	F 248	1. Full time activity director started on 1/2/2017. 2. Activity Director attended the resident counsel on 1/3/2017, was introduced to all of the residents that attended the meeting and reviewed different activities that they liked to participate in and what activities they would like to see. Residents that attended the resident counsel was able to pick certain activities that they wanted. 3. Activity Director was introduced to all residents in long term care on 1/3/2017. 4. Activity Director has been educated that there needs to be a minimum of 2 activities per day 7 days a week not including the church services provided on Sundays. 5. A QA/QI project will be created to ensure that 2 activities are offered each day and this will be monitored monthly	02/08/2017

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F 248	Continued From page 10 the December 2016 calendar for the 5th, 8th, 26th, 27th, and 29th. 2. Interview on 1/4/17 at 10 AM with resident #17 revealed there were no regular activities on weekends. The resident liked the activities that were provided, but wanted more activities, especially on the weekends. 3. Interview on 1/4/17 at 12:30 PM with five residents revealed four of the five residents attending felt there were not enough activities provided, particularly on weekends. Further, one resident stated "There's not enough activities for the guys." 4. Interview with the DON on 1/5/17 at 11:50 AM revealed the facility had failed to create an activity calendar for October 2016, and confirmed the facility sometimes had deficits in the area of activities, especially on weekends.	F 248		
F 249 SS=D	483.24(c)(2)(i)(ii) QUALIFICATIONS OF ACTIVITY PROFESSIONAL (c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or	F 249	1. South Lincoln Nursing Center will have a contract in place with an activities director that meets the requirements of the state. This individual with whom we contract with will work with and provide supervision to the current full time activities direct. 2. South Lincoln Nursing Center will create a QA/QI project to track the monthly visits and any recommended changes to ensure that we are following states rules and regulations.	02/08/2017

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	53A061	A. BUILDING _____ B. WING _____	01/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH LINCOLN NURSING CENTER	711 ONYX STREET KEMMERER, WY 83101

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F 248	Continued From page 11 (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on review of personnel files, and staff interview, the facility failed to ensure activity director qualifications were met. The resident census was 17. The findings were: Interview on 1/3/17 at 4:15 PM with the DON revealed the current activity director started in that position on 1/3/17 and there was no active activity director from late September 2016 until 1/3/17. She stated the former activity director had taken leave and the facility had anticipated her return to duty. During that timeframe, the DON and social services director attempted to set-up activities and have staff carry them out. Review of the personnel record for the current activity director showed she did not have the qualifications or experience required for the position, which would include one of the following: 2 years of experience, being a qualified occupational therapist or occupational therapy assistant, or having completed a state approved training course. Interview with the DON on 1/5/17 at 11:50 AM confirmed the current activity director did not have the qualifications or experience required. The plan was for the activity director to pursue and obtain those requirements.	F 249		

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F 253	Continued From page 12	F 253		
F 253 SS=E	483.10(l)(2) HOUSEKEEPING & MAINTENANCE SERVICES (l)(2) 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 3 of 3 resident areas (resident rooms, common areas and hallway, tub room) were clean and in good repair. The findings were: 1. Observation on 1/5/17 between 11:33 AM and 12:08 PM revealed the following environmental concerns in resident rooms: a. In room #103 the bathroom sink had a leaking faucet that would not stop dripping when the faucet handles were in a closed position. b. In room #104 a wall had damage measuring 7 inches by 2 3/4 inches which exposed underlying drywall. Further, there were cracks in the bathroom linoleum near the sink measuring 14 inches by 1/4 inch, and near the toilet measuring 5 1/2 inches by 1/4 inch creating a non-cleanable surface. c. In room #105 a wall at the room entrance had damage measuring 2 inches by 1 1/2 inches and 1 1/2 inches by 3/4 inch which exposed underlying drywall creating a non-cleanable surface. d. In room #106 there were cracks in the bathroom linoleum near the sink measuring 5 inches by 1/4 inch and by the toilet measuring 3 1/2 inches by 1/4 inch which created an non-cleanable surface. e. In room #107 there was a chip in the inner bathroom door measuring 1 inch by 1 inch which	F 253	1.A-The leaking faucet in room #103 will be replaced by February 8, 2017. 1.B-The walls in room #104 will be repaired and painted by February 28, 2017 and the damaged bathroom linoleum will be replaced by February 28, 2017. 1.C-The walls in room #105 will be repaired and painted by March 31, 2017. 1.D- The bathroom linoleum in room #106 will be replaced by March 31, 2017. 1.E-The walls in room #107 will be repaired and painted by April 30, 2017. 1.F- The walls in room #114 will be repaired and painted by April 30, 2017. 1.G-The walls in room #115 will be repaired and painted by April 30, 2017. 2. A,B,C,D,E,F,G,H,I,J,K,L, and M the carpet and all hallways and commons areas will replaced with new flooring by June 15, 2017. 3.A- The linoleum in the tub/bathroom will be replaced by March 31, 2017. The Plant Operations Manager will monitor to ensure compliance is met. Quarterly, maintenance employees will inspect all residents rooms and LTC facility tracking needed repairs and reporting on a QA/QI project.	02/08/2017 02/15/2017

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F 253	Continued From page 13 created an non-cleanable surface. f. In room #114 the wall corner by the bathroom had damage measuring 8 inches which exposed underlying metal creating a non-cleanable surface. g. In room #115 the wall corner by the bathroom had damage measuring 10 1/2 inches which exposed underlying metal creating a non-cleanable surface. 2. Observation on 1/5/17 between 12:11 PM and 12:31 PM revealed the following environmental concerns the in common areas and hallway: a. The hallway carpet across from room #103 had a 5 inch by 2 inch bleach-like stain. b. The hallway carpet across from room #106 near the nurse's station had a 2 inch by 1 inch dark stain. c. The hallway carpet near room #107 had a 2 inch by 1 inch dark red stain. d. The hallway carpet near room #108 had a 6 inch line of bleach-like stains. e. The hallway carpet across from room #109 had a 14 inch by 7 inch bleach-like stain. f. The hallway carpet in front of room #111 had a 1 inch by 1 inch dark stain. g. The hallway carpet near room #113 had a 10 inch by 14 inch and a 1 inch by 1 inch dark stain. h. The hallway carpet near room #115 had a 3 inch by 4 inch dark stain. i. The carpet near the break room had a 12 inch by 4 inch dark stain. j. The carpet outside of the dining room had a 29 inch by 12 inch dark red stain. k. The carpet in front of the television in the common area had a 6 inch by 6 inch dark red stain. l. The carpet in front of the exit doors near the	F 253		

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F 253	Continued From page 14 television common area had a 55 inch by 44 inch dark stain. m. The carpet in front of the ottoman near the nurse's station had a 26 inch by 16 inch dark stain. 3. Observation on 1/5/17 at 12:32 PM revealed the following environmental concerns in the tub/bath room: a. The linoleum seams had gaps measuring 23 inches by 1/3 inch and 15 inches by 1/4 inch, creating a non-cleanable surface. b. There were three 2 inch by 2 inch tiles in the tub area which were cracked, creating a non-cleanable surface. 4. Interview on 1/5/17 at 4:07 PM with the maintenance supervisor revealed the facility had identified some of the areas; however, there was no timeline for correction. He reported the carpet replacement had been budgeted for "every year" but they "had not been able to get around to it." Further, he confirmed areas were visibly dirty and/or in disrepair and required maintenance.	F 253		
F 257 SS=E	483.10(l)(8) COMFORTABLE & SAFE TEMPERATURE LEVELS (l)(8) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81 degrees F. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, the facility failed to ensure temperatures in resident bathrooms were kept at a safe and comfortable level in 7 of 10 bathrooms (#104, #105, #107, #111, #113, #114, #115)	F 257	There will be radiant ceiling heaters in all resident bathrooms 10 of 10 installed by March 15, 2017 to ensure temperatures in residents bathrooms are kept at a safe and comfortable level. Plant Operations Manager will monitor to ensure compliance is met. Holbrook Service and order confirmation from Grainger shows heaters with ceiling mounts for all 10 bathrooms. Quarterly, the maintenance department will check 50% of LTC resident bathroom temps and report QA/QI project.	02/08/2017

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F 257	Continued From page 15 assessed for temperature. The findings were: 1. Observation on 1/5/17 at between 11:33 AM and 1:13 PM revealed the following environmental concerns in resident bath rooms: a. In room #104 the bathroom air temperature measured 68 degrees Fahrenheit (F.). b. In room #105 the bathroom air temperature measured 68.9 degrees F. c. In room #107 the bathroom air temperature measured 69.6 degrees F. d. In room #111 the bathroom air temperature measured 60.6 degrees F. e. In room #113 the bathroom air temperature measured 63.0 degrees F. f. In room #114 the bathroom air temperature measured 61.7 degrees F. g. In room #115 the bathroom air temperature measured 69.8 degrees F. 2. Interview on 1/4/17 at 12:30 PM with five residents revealed one resident felt his/her bathroom was "Always cold, like an outhouse." Other residents present agreed the bathrooms are colder than the temperature in the living area of their rooms. 3. Interview on 1/5/17 at 2:35 PM with the DON revealed that the cold bathrooms, specifically rooms #113, #114, and #115 had been reported to maintenance "several times." She further stated the facility had previously gone for a week without giving baths in the tub room due to the cold condition of the room. 4. Interview on 1/5/17 at 4:07 PM with the maintenance supervisor revealed he could "definitely tell" the bathrooms visited during the	F 257		

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F 257	Continued From page 16 facility walk-through were colder than the main living areas. He further stated he felt the temperatures could be adjusted.	F 257		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in	F 272	1. South Lincoln Nursing Center is unable to correct any of the citations on residents #11, #12, #13, #14, #15, #16 and #17 due to the required information not in the residents chart for the MDS coordinator to pull the information, also these have already been submitted to the state and we are unable to correct them. 2. SLNC was without a MDS coordinator until the first part of September 2016. Upon hire the MDS coordinator was working with local nursing home in Evanston to better understand the MDS and learn how everything correlates. 3. Currently as of today 2/7/17 the MDS coordinator is ensuring that the triggered CAA areas are on the care plans and assessments are being documented. 4. MDS coordinator will obtain certification in the next year to. 5. SLNC already has a QA/QI project in place to ensure that every resident is having a weekly head to toe assessment performed and documented to ensure that the required information is charted for the MDS Coordinator. 6. MDS coordinator will monitor and ensure all CAA's are being completed per triggered areas on the QA/QI project and report it monthly to the Nurse Manager. We will add the project to our tracking list to ensure that we have appropriate information.	02/08/2017

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F 272	Continued From page 17 assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to complete required assessments triggered by the completion of the MDS for 7 of 7 sample residents (#11, #12, #13, #14, #15, #16, #17). The findings were: Medical record review for 7 sample residents (#11, #12, #13, #14, #15, #16, #17) showed each had comprehensive MDS assessments. The following concerns were identified: a. Review of the 4/28/16 annual MDS assessment for resident #11 showed the assessment was completed. However, no CAAs were completed for the triggered areas at section V, and no referral to corresponding assessments was documented. b. Review of the 12/8/16 annual MDS assessment for resident #12 showed the assessment was completed. However, no CAAs were completed for the triggered areas at section V, and no referral to corresponding assessments was documented. c. Review of the 4/23/16 annual MDS assessment for resident #13 showed the	F 272		

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F 272	Continued From page 18 assessment was completed. However, no CAAs were completed for the triggered areas at section V, and no referral to corresponding assessments was documented. d. Review of the 9/9/16 annual MDS assessment for resident #14 showed the assessment was completed. However, no CAAs were completed for the triggered areas at section V, and no referral to corresponding assessments was documented. e. Review of the 3/1/16 annual MDS assessment for resident #15 showed the assessment was completed. However, no CAAs were completed for the triggered areas at section V, and no referral to corresponding assessments was documented. f. Review of the 7/28/16 admission MDS assessment for resident #16 showed the assessment was completed. However, no CAAs were completed for the triggered areas at section V, and no referral to corresponding assessments was documented. g. Review of the 3/2/16 annual MDS assessment for resident #17 showed the assessment was completed. However, no CAAs were completed for the triggered areas at section V, and no referral to corresponding assessments was documented. h. Interview with the MDS coordinator on 1/5/17 at 10 AM confirmed the facility failed to complete CAAs. She believed that the triggered areas under section V completed the process, and she then proceeded to care plan updates as needed.	F 272		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility	F 274		

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F 274	Continued From page 19 determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the resident assessment instrument user's (RAI) manual, the facility failed to complete a significant change MDS assessment for 2 of 7 sample residents (#12, #13) who required that assessment. The findings were: 1. Review of the medical record showed resident #12 was admitted to the facility on 2/14/13 with diagnoses that included dementia, chronic pain, depression, diabetes mellitus, anxiety and gastroesophageal reflux disease (GERD). Review of the 12/9/15 annual MDS assessment showed the resident only required set-up for eating, and had no upper extremity limitations. When compared to the 12/9/16 annual MDS assessment, the review showed the resident had a decline in activities of daily living regarding eating, and required the total assistance of one person. Further, the resident had upper extremity limitations affecting both sides. 2. Review of the medical record showed resident #13 was admitted to the facility on 4/15/15 with diagnoses that included congestive heart failure,	F 274	1. SLNC is unable to correct the cited residents #12 and # 13 due to MDS coordinator was not notified of the change in condition in a timely manner to meet the requirements. 2. Weekly stand up meetings are being held with Activity Coordinator, Pharmacy, Respiratory, Dietary, Restorative Aide, Nurse Manager review all department issues, resident issues or complaints, upcoming events and any resident change in condition that has happened so that it can documented in the MDS accurately. 3. Nurse Manager updates MDS daily when she is here regarding any changes in residents and the possibility of any change in condition. 4. If it is determined that a significant change in condition has occurred and is required, the MDS coordinator will set the date in the system, compare prior MDS to the significant change and have submitted within the 2 week period of time. 5. QA/QI monitoring and tracking plan will be set up and tracked monthly regarding notification date of change in condition, determinate date that a sign change needs to be done and when the MDS was compared and submitted.	02/08/2017

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F 274	Continued From page 20 hypertension, gastro-esophageal reflux disease, depression, and macular degeneration. Review of the 4/23/16 annual MDS assessment showed the resident was independent with bed mobility, transfer, walking in his/her room, walking in the corridor, with locomotion on the unit, with locomotion off of the unit, and with toilet use. The assessment also showed the resident required limited assistance from one staff member with personal hygiene and bathing. In addition, the resident only required set-up for eating. Review of the 7/21/16 quarterly MDS assessment showed the resident required limited assistance of one staff member for dressing, toilet use, and bathing, but was otherwise independent. When compared to the 10/24/16 quarterly MDS assessment, the review showed the resident had a decline in the following ways: the resident required extensive assistance from one staff member with bed mobility, transfer, dressing, eating, toilet use, personal hygiene, and bathing. The resident also required limited assist from one staff member for walking in his/her room, walking in the corridor, locomotion on the unit, and locomotion off of the unit. 3. Interview with the MDS coordinator on 1/5/17 at 10 AM confirmed the facility failed to complete a significant change MDS assessment for residents #12, and #13. 4. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.14, October 2016 showed "The SCSA (Significant Change in Status Assessment) is a comprehensive assessment for a resident that must be completed when the IDT (Interdisciplinary Team) has determined that a resident meets the significant change guidelines	F 274	1. MDS coordinator used dashes when the information was not available for the residents or could not be verified. 2. Nurses currently and have been since mid-September performing weekly assessments on every resident in the facility to ensure prior documentation, to catch any possible change prior to it becoming an emergency and to ensure proper care of the residents. This will continue to be on-going. 3. Pain interviews are being done on every resident in the facility when their MDS's are due. 4. The MDS coordinator continues to self-educate by reading the RAI manual and coordinating departments on timings for their sections. MDS coordinator hands out a monthly schedule on when residents are due for MDS's and which sections everyone is responsible for.	02/08/2017

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F 274	Continued From page 21 for either improvement or decline." It further stated "A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement".	F 274		
F 278 SS=E	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.	F 278	1) We at SLNC are unable to correct the identified issues with residents #11, #12, #13 and #16 due to them already being sent in and the required documentation was missing in the residents charting. 2) Nurses are now and have been performing weekly assessments on every resident to ensure proper documentation, catch any possible changes prior to an emergency happening and to ensure proper care of residents. 3) This has and will continue to be a monthly QA/QI project to ensure weekly nursing assessments are being done on every resident. This is added the QA/QI tracking sheet and is reported on monthly.	

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F 278	Continued From page 22 (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the accuracy of MDS assessments for 4 of 7 open sample residents (#11, #12, #13, #16). The findings were: 1. Review of the 10/26/16 quarterly MDS assessment for resident #11 showed the area for decision of whether or not a pain interview should take place was left blank, and the facility failed to interview or assess the resident for potential pain issues. 2. Review of the 9/11/16 quarterly MDS assessment for resident #12 showed the areas of short term and long term memory, delirium, mood and behaviors, and depression severity score had been marked with dashes, indicating these items were not assessed. Further, the 12/9/16 annual MDS assessment of resident preferences was marked "none of the above" and overlooked previous preferences that were assessed on his/her 12/9/2015 annual MDS assessment. 3. Review of the 10/24/16 quarterly MDS assessment for resident #13 showed the area for decision of whether or not a pain interview should take place was left blank, and the facility failed to interview or assess the resident for potential pain issues. 4. Review of the 7/28/16 admission MDS assessment for resident #16 showed the area for previous falls before entering the facility was marked as "unable to determine." However, nurse's notes dated 7/21/16 indicate that the	F 278		

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F 278	Continued From page 23 resident had "bruise noted to left fore [sic] from previous fall" and on 7/22/16 showed "...since being in the hospital status post fall" and "...is a SBA (stand by assist) and has a hx (history) of falls". 5. Interview with the MDS coordinator on 1/5/17 at 10 AM confirmed she sometimes left areas on the MDS blank by placing a dash there. She stated that if she did not know the answer, a dash was what she coded.	F 278		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) 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-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is	F 431	1. Nurses were provided education on 1/18/2017 about facility policy regarding locking of the med cart and when it does not have to be locked (cart within eye sight). All nurses verbalized understanding. 2. QA/QI project was created to monitor the number of times in a day the cart is found to be unlocked or out of the nurse's eye sight. The project will begin in February and be on-going.	02/08/2017

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F 431	Continued From page 24 maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure drug access was restricted to only authorized personnel for 1 of 1 medication carts. The findings were: Observation on 1/4/17 at 11:24 AM showed a medication cart placed near the nurse's station with its drawers facing outward was unlocked and unsupervised. The cart remained unsupervised until 11:37 AM when LPN #1 returned to the cart. The cart was locked at 11:40 AM. Observation on	F 431		

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F 431	Continued From page 25 1/4/17 at 7:01 PM showed LPN #2 left the medication cart unlocked and unattended while she gave medications in a resident room. She returned to the cart at 7:03 PM. Observation on 1/4/17 at 7:17 PM showed LPN #2 left the medication cart unlocked and unattended while she gave medications in a resident room. She returned to the cart by 7:20 PM. Interview on 1/5/17 at 2:35 PM with DON revealed the expectation of the facility is whenever the medication cart is not in the line of sight of the nurse it is to be locked up. The nurse is permitted to have the medication cart unlocked if s/he is at the nurse's station and can monitor the cart.	F 431		
F 441 SS=D	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	F 441	1. On 1/18/2017 all staff were educated on a. Whom to report a possible infection b. What a possible infection could be c. Not to touch any resident medications with their bare hands and this is an infection control issue. d. How to administer fresh ice water to each resident 4 times a day without spreading infection. (it was demonstrated how the staff usually pass water and then we discussed/broke it down regarding the infection disease issues) Staff came up with an appropriate solution that they will be trying to perform. 2. Starting 2/1/2016 a daily water pass will be observed with attention paid to "infectious control". A QA/QI project has been started to monitor this daily with a pass or fail, after 2 weeks of results we will then have another staff training to further discuss options to improve our infectious control rate.	02/08/2017

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F 441	Continued From page 26 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; (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. (s) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 27 (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 and staff interview, the facility failed to ensure standard transmission-based precautions to prevent spread of infections were followed for 2 of 2 random observations. The findings were: 1. Observation on 1/4/17 at 7:27 PM showed LPN #2 brought a medication cup with pills to a resident's room for administration. The nurse emptied the pill cup into the resident's hand, however, one of the pills dropped into the resident's lap. The nurse picked up the pill with her bare hand and placed it back into the resident's palm. 2. Observation on 1/5/17 at 3:46 PM showed an unidentified staff member was passing ice water to residents using a cart, ice cooler, and scoop. The staff member was wearing gloves to enter resident room #104 to retrieve the resident's water mug. After touching the used mug, the staff member used the same gloved hand to hold the ice scoop, place ice in the mug, and placed the scoop into the ice. She then returned to the resident's room. Inspection of the ice cooler revealed the scoop was laying in the ice, with the handle touching the ice. Upon returning to the hallway the staff member removed her gloves and donned a new pair. The staff member repeated the process when providing ice to room #105. 3. Interview with the ICP on 1/5/17 at 3 PM confirmed staff should wash hands between	F 441		

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F 441	Continued From page 28 tasks, and not handle medications with bare hands.	F 441		
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting of a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this	F 520	1. South Lincoln Medical Center (which includes the nursing center) has set up a QA/QI committee which consists of a EMS Manager, Office Manager, Utilization Review Coordinator, Nurse Manager, Administrator, LTC Medical Director and Chief of Staff. This was effective Nov, 2016. 2. The QA/QI committee meets on a monthly basis to review hospital wide QA/QI projects as well as each individual department projects. Each department is being asked to attend a meeting to review their projects with the committee. 3. Each individual department reports on their own projects and tracks them then turns them into the committee on a monthly basis for continued reporting and tracking. 4. Long Term Care also turns in all of their tracking information to the committee. Long Term Care communicates with Dietary and Respiratory regarding updates on QA/QI projects. 5. SLNC will have add Respiratory, Maintenance, Laundry and Dietary projects onto the tracking sheet for long term care so their numbers are present as well. This will be an on-going thing. 6. A QA/QI project has been made to track the number of activities held daily to ensure rules and regs are being followed. Activity coordinator gives a monthly activity schedule and also has a daily sign in sheet so we can also track which residents attend which activities. Clarification: Nurse manager is also the DON for both Critical Care and LTC. The Medical Director for LTC has also been included for the quarterly meeting.	02/08/2017

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F 520	Continued From page 29 section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of QA (quality assurance) meeting minutes, review of 1/6/16 recertification survey results, and staff interview, the facility failed to ensure an effective QA program that represented the full range of care and services provided by the facility. In addition, the committee failed to meet at least quarterly. The findings were: Review of QA meeting minutes showed the facility had meetings on 10/27/16, 11/10/16, and 12/8/16. The following concerns were identified: a. Review of the 10/27/16 QA committee meeting minutes showed the QA committee failed to adequately address the following areas: dietary, infection control, activities, housekeeping, and building maintenance. Also, evidence of analysis of the data brought forth in the meeting for determination of specific interventions to address identified issues was lacking. b. Review of the 11/10/16 QA/QI committee meeting minutes revealed three staff members were present. The meeting discussed coordination of future meetings without any other substantial information provided. c. Review of the 12/8/16 QA/QI committee meeting minutes showed the QA committee failed to adequately address the following areas: dietary, infection control, activities, housekeeping, and building maintenance. Also, evidence of analysis of the data brought forth in the meeting	F 520		

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F 520	Continued From page 30 for determination of specific interventions to address identified issues was lacking. d. Review of the 1/6/16 recertification survey showed the facility was cited for deficiencies in their activity program, and the activity program continued to be insufficient to meet the needs of the residents. e. Interview with the DON on 1/5/17 at 3:05 PM revealed the first QA meeting she attended was the 10/27/16 meeting. She further stated the facility was unable to produce evidence of QA meetings for 2016 prior to that, and the only documentation for QA she could find was for 2015. She was unable to provide documentation to show the QA program had addressed issues cited on the 1/6/16 recertification survey, and the activities program cited at that time remains an issue. She stated the QA committee was still a work in progress.	F 520		