PRINTED: 06/07/2017
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535036	A. BUILDING _____ B. WING _____	C 05/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS REHABILITATION AND WELLNESS	542 16TH STREET RAWLINS, WY 82301

(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 complaint survey was conducted by Healthcare Licensing and Surveys on 5/21/17 through 5/24/17. The complaint survey was generated by complaint intake WY00002240 and WY00002272. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living CDM- Certified Dietary Manager CNA- Certified Nurse Aide DNS- Director of Nursing Services HA- Hospitality Aide LPN- Licensed Practical Nurse MAR- Medication Administration Record MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of the deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(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 a safe and sanitary environment in 4 of 4 resident areas (front, middle, back and dining areas. The findings were: 1. Observation on 5/23/17 beginning at 10 AM and again on 5/24/17 at 9:15 AM showed the following concerns with resident rooms:	F 253	F253 Corrective action: Maintenance manager/designee. Areas identified in room 37, room 36, shared bathroom between rooms 42 and 43, cove bases in rooms 5,47,48, sink in room 19, blinds and radiator cap in room 25, cove bases in room 26, 28 and 36, areas identified in room 4 have all been cleaned, repaired or replaced as appropriate. Wood blinds in dining room were dusted. ID of others: Maintenance manager/designee. Environmental rounds to determine whether there are additional needs for paint, repair or dusting. Any identified areas will be repaired.	6/25/17

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Annette Rigdon DNS | TITLE: DNS | (X6) DATE: 7/5/17

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.

RECEIVED JUL 05 2017 Healthcare Licensing and Surveys

Jean Finni 7/5/17

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: XTCS11 Facility ID: WY0029 If continuation sheet Page 1 of 33

Plan of Correction accepted. Naomi King, EI notified at 4:47 pm on 7/5/17. DOC is 6/25/17.

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F 253	Continued From page 1 a. The cove base around the perimeter of room #37 was discolored with a buildup of wax and dirt. The second drawer beneath the closet, closest to the entry door, had a 1 3/4 by 3 1/4 inch broken section which exposed the underlying particle board. The wall behind the nightstand, closest to the hallway, had a 10 inch long section of multiple, irregular shaped, chipped areas which exposed the dry wall. The window blinds were dirty and had broken slats. b. The shared bathroom between room #36 and #37 had a buildup of dust on the ventilation fan. The wall at the base of the door to room #36 showed a 4 1/2 by 5 inch section was missing the cove base. The exposed wall had crumbled plaster and drywall which could not be cleaned effectively. The radiator was discolored with a buildup of dirt and debris. c. The shared bathroom between room #42 and #43 had a buildup of dust on the ventilation fan. The wall at the base of the door to room #42 showed a 4 1/2 by 5 inch section was missing the cove base and exposed the dry wall and the metal corner plate. The radiator was discolored with a buildup of dirt and debris. d. The cove base around the perimeters of room #5, #47 and #48 was discolored with a buildup of wax and dirt. e. The bathroom sink in room #19 had a 14 inch crack which started at the top of the sink above the hot water knob and ended just left of the drain. A second crack, 6 inches long, started at the right upper corner of the sink. Water leaked from beneath the hot water knob when it was in the "on" position. The window blinds were dirty and had broken slats. f. The blinds in room #25 were dirty and had broken slats. The radiator in the bathroom had a loose end cap which exposed sharp edges and	F 253	Systemic Changes: Maintenance manager/designee. All staff education in-service on use of maintenance forms, identification of areas of concern/need of repair. Areas identified during environmental rounds to be added to maintenance schedule for repair. Monitoring: Maintenance manager/designee to conduct environmental rounds, results to be taken to QAPI to determine need for frequency/duration of monitoring.	

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F 253	Continued From page 2 was discolored with a buildup of dirt and debris. g. The cove base around the perimeters of room #26, #28 and #36 was discolored with a buildup of wax and dirt. The blinds were covered in dust. h. In room #4 the metal edge protector on the wall to the left of the bathroom door was held to the wall with two 2 inch wide sections of black tape. The lower section of tape was frayed and had pulled away from the wall. The bathroom door kick plate was held to the door with a piece of 2 inch wide black tape. A section of damaged wall in the bathroom on the right hand side, upon entry, measured 23 inches long and 3 inches wide and was located 12 inches from the floor. A 14 foot long by 3 1/2 inch wide and 3/4 inch deep wood board extended the length of the room behind the head of the beds. The board had multiple areas of splintered wood and was loose from the wall. The cove base around the perimeter of the room was discolored with a buildup of wax and dirt. The blinds were covered with dust. 2. Observation beginning on 5/21/17 at 4:20 PM through the end of the survey on 5/24/17 in the dining areas showed 8 sets of wood blinds located on the south side of the dining room and 4 sets of wood blinds located on the north side of the dining room were dusty and dirty to the touch. 3. Interview on 5/23/17 at 2:05 PM with the housekeeping manager revealed his goal was to deep clean 2 resident rooms per week, but he stated "in reality" only one gets done. He verified the identified areas needed to be cleaned. 4. Interview on 5/24/17 at 9:15 AM with the maintenance manager revealed he coordinated	F 253		

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F 253	Continued From page 3 with the housekeeping manager and made repairs to the resident rooms that were being deep cleaned. He verified the identified areas needed to be repaired.	F 253		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility 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 MDS 3.0 RAI (Resident Assessment Instrument) manual, the facility failed to ensure a significant change assessment was completed for 2 of 4 residents (#22, #30) with a significant change. The findings were: 1. Review of the quarterly MDS assessment dated 1/4/17 showed resident #30 understood and was understood, scored 0 (no depression) on the mood interview, was always continent of bowel and bladder, and did not take antipsychotic medication during the look back period. Review of the quarterly MDS assessment dated 4/6/17 showed the resident usually understood and usually was understood, scored 11 (moderate	F 274	F274 Corrective Action: MDS Coordinator/designee. Significant change of condition was completed on residents 22 & 30. ID of others: MDS Coordinator/designee to audit all MDS completed the last three months to determine if any other resident was appropriate for MDS Significant Change of Condition Assessment. Any residents identified will have a significant change assessment completed Systemic change: Corporate UR nurse Education provided to MDS coordinator for criteria for need of significant change assessment per CMS guidelines. Monitoring: All MDS error reports to be reviewed at IDT meeting to determine whether significant change of condition is warranted. Results of audits to be taken to QAPI to determine frequency/duration of continuing audits.	6/25/17

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F 274	Continued From page 4 depression) on the mood interview, was frequently incontinent of urine, was occasionally incontinent of bowel, had a non-physician prescribed weight loss, and used antipsychotic medication for 7 days during the look back period. Interview on 5/23/17 at 4:25 PM with the MDS coordinator confirmed a significant change assessment should have been completed. 2. Review of the 9/16/16 significant change MDS assessment showed resident #22 required limited assistance with 1 person physical assist for ADLs which included transfers, ambulation, locomotion, and dressing. The resident required supervision for eating. In addition, the resident was occasionally incontinent of urine. Review of the 12/20/16 and the 3/15/17 quarterly MDS assessments showed the resident had experienced a significant improvement in these areas. The resident became independent for transfers and eating, and required supervision with set-up help only for ambulation, locomotion, and dressing. In addition, the resident improved to being continent of urine. Interview with the MDS coordinator on 5/24/17 at 11:08 AM confirmed a significant change MDS assessment was not completed related to these improvements. 3. Review of the "CMS RAI version 3.0 manual, October 2016, showed "...04. Significant change in status assessment (SCSA) (A0310A=04)...other conditions may not be permanent but would have such an impact on the resident's overall status for more than two weeks that they would require a comprehensive assessment and care plan revision. For example, a hip fracture may be viewed as a transient condition but it would generally have a major	F 274		

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F 274	Continued From page 5 impact on the resident's functional status in more than one area (e.g. ambulation, toileting, elimination patterns, activity patterns)..." Continued review showed "...Decline in two or more of the following...any decline in an ADL (activities of daily living) physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment." Further, the RAI stated a significant change assessment is appropriate when "...There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent Comprehensive assessment and any subsequent Quarterly assessments..."	F 274		
F 278 SS=D	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	F 278	F278 Corrective Action: MDS coordinator/designee. Modification assessment for resident 30's 4/6/17 quarterly MDS has been modified to reflect fall and pain medication administered. Modification assessment for 9/16/16 Significant Change MDS has been changed to reflect anti-psychotic medication. ID of others: DNS/designee conduct an audit of MDS assessments completed over last three months for accuracy. Incorrect assessments will have Modification Assessments completed. Systemic changes: MDS assessments will be reviewed for accuracy by DNS/RN/designee prior to submission. Monitoring: Results from MDS Results of audits to be taken to QAPI to determine frequency/duration of continuing audits.	6/25/17

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F 278	Continued From page 6 (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. (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 MDS assessments were accurately completed for 2 of 9 sample residents (#22, #30). The findings were: 1. Review of the 4/6/17 quarterly MDS assessment for resident #30 showed inaccuracies in the following areas. a. Review of section J1700 revealed the resident had not had any falls since the prior assessment dated 1/4/17. Review of a nurse's note dated 2/5/17 and timed 7:05 AM showed "Resident found on floor, sitting & back up against bed." A fall evaluation was completed on 2/5/17. b. Review of section J0100 showed the resident did not receive pain medication within the assessment look-back window (4/2/17 to 4/6/17). Review of the April 2017 medication administration record showed the resident received hydrocodone-acetaminophen (a pain medication) 7.5-325 mg on 4/3 and 4/4.	F 278		

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F 278	Continued From page 7 c. Interview on 5/23/17 at 4:25 PM with the MDS coordinator confirmed the fall and medication were not coded accurately on the quarterly MDS assessment for resident #30. 2. Review of the 9/16/16 significant change MDS assessment showed resident #22 had diagnoses which included dementia, anxiety, and depression. Review of the May 2017 recapitulation of physician orders showed on 8/27/16 the resident was started on a lowered dose of Risperdal (an antipsychotic medication) for the diagnosis of dementia with behaviors. The order was for 0.5 mg daily. Further review of the 9/16/16 significant change MDS failed to show the resident used antipsychotic medications daily. Interview with the MDS coordinator on 5/24/17 at 11:08 AM revealed this was an inaccuracy on the MDS assessment.	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that	F 279	F279 Corrective action: MDS coordinator/designee. Residents number 6 and 16 had comprehensive care plans completed/updated. ID of others: MDS Coordinator/Designee. A random audit of current care plans will be completed for needed updates. Any care plans identified as incomplete will be completed/updated. Systemic changes: Care plans will be reviewed on 14 day, all new admissions and quarterly thereafter. Monitoring: DNS/designee. Conduct a random audit of care plans every month for the next three months. Results of audits to be taken to QAPI to determine frequency/duration of continuing audits.	6/25/17

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F 279	Continued From page 8 includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (I) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 279		

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F 279	Continued From page 9 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to develop and implement a comprehensive, person-centered care plan for 2 of 9 sample residents (#6, #16). The findings were: 1. Review of the 3/7/17 quarterly MDS assessment showed resident #6 required the extensive assistance of 1 person for eating, was severely impaired for daily decision making, had a tube feeding and was on a mechanically-altered diet. Review of the April 2017 physician order recapitulation showed the resident was on a regular soft diet with nectar-thickened liquids and pureed vegetable and fruit, with small portions. Interview with the MDS coordinator on 5/23/17 at 3:22 PM revealed the resident ate well, "often 100%" when his/her family brought food. Interview with LPN #1 on 5/23/17 at 4:17 PM revealed the resident also used a feeding tube for nutrition because s/he ate poorly except when his/her family brought food the resident liked. Review of a nurse's note dated 3/17/17 at 6:30 PM showed, "[Family] brought resident homemade meal - resident smiling eating." The following concerns were identified: a. Observation on 5/21/17 at 12 PM and at 5:43 PM showed the resident was served a meal in the main dining room. The resident sat alone at the table and made no attempt to eat during either meal time. There was no interaction from staff with the resident at either meal. b. Review of the care plan updated 4/26/17 related to nutrition showed the resident's level of	F 279		

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F 279	Continued From page 10 assistance with dining varied from cueing to totally dependent. Further, the plan showed the resident ate in either the main or assisted dining room. The care plan failed to show any indication of when staff were to provide more or less assistance. Further the care plan failed to address the resident's cultural preferences. c. Review of the care plan updated 4/26/17 related to tube feeding showed there were no details for when and how the tube feeding was to be administered other than "as ordered by physician." The reason for the tube feeding was shown to be abnormal lab values, cognitive issues, and obesity. The plan also failed to address when or if the tube feedings should be held due to resident eating by mouth. 2. Review of the 3/16/17 admission MDS assessment showed resident #16 required the extensive assistance of 1 person for eating. The resident was totally dependent for all additional ADLs and was severely cognitively impaired. Review of a Speech Language Pathologist (SLP) progress note dated 3/27/17 at 1 PM showed the recommended positioning of the resident for eating and drinking was for the resident's upper body to be elevated at a 45 degree angle. The following concerns were identified: a. Observation on 5/21/17 at 12 PM showed the resident was in the assisted dining room. The resident was reclined in a specialty geriatric wheelchair. The resident's upper body was positioned approximately at a 20 to 25 degree angle. The resident periodically coughed while s/he was fed and provided fluids. b. Review of the care plan updated 5/8/17 related to nutrition and hydration showed the resident was totally dependent for eating and drinking and required aspiration precautions.	F 279		

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F 279	Continued From page 11 However, the care plan failed to include the positioning of the resident as recommended by the SLP. c. Interview with the DNS on 5/23/17 at 5:45 PM confirmed the positioning of the resident should be included on the care plan.	F 279		
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 observation, medical record review, and staff interview, the facility failed to ensure care was provided in accordance with the written plan of care for 2 of 9 sample residents (#6, #30). The findings were: 1. Review of the 4/6/17 quarterly MDS assessment showed resident #30 had diagnoses which included hypertension, diabetes mellitus, and depression. Review of the of the diabetic care plan for resident #30 dated 10/4/16 showed planned interventions included "monitor PO (by mouth) intake." The following concerns were identified: a. Review of the April 2017 meal monitor flowsheet showed the amount of food and fluid consumed by the resident was not documented for 26 of 90 meals. b. Review of the May 2017 meal monitor	F 282	F282 Corrective action: MDS/designee. Residents number 30 and 6 had care plans reviewed and updated. Meal monitors were reviewed for resident number 30, resident number 6 was moved to assisted dining. ID of others: MDS/designee. An audit will be conducted on current residents to ensure care is provided in accordance with written plan of care. CDM/Designee will conduct a random audit 3 times a week to ensure completion of meal monitor. Systemic changes: All clinical staff in-service education on services to be provided per plan of care. All clinical staff to be trained on meal monitors. Monitoring: Results of random care plan audits and 3 times per week meal monitor audits Results of audits to be taken to QAPI to determine frequency/duration of continuing audits.	6/25/17

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F 282	Continued From page 12 flowsheet from 5/1 through 5/21 showed the amount of food and fluid consumed by the resident was not documented for 20 out of 63 meals. c. Interview on 5/23/17 at 3:50 PM with the CDM revealed the CNAs and HAs usually recorded the meal intake amounts after the meal service. She only reviewed the flowsheets on a quarterly basis and further verified there were gaps in the documentation. 2. Review of the 3/7/17 quarterly MDS assessment showed resident #6 required the extensive assistance of 1 person for eating and was severely impaired for daily decision making. Review of the care plan updated 4/26/17 related to nutrition and hydration showed the resident had varied needs for assistance and was to be brought to the table for socialization. The care plan showed the resident dined in either the assisted or main dining room. The following concerns were identified: a. Observation on 5/21/17 at 12 PM and again at 5:43 PM showed the resident was served a meal in the main dining room. The resident made no attempt to eat and sat alone with no interaction with staff or other residents for the duration of the meal times. Observation on 5/23/17 at 7:58 AM showed the resident sat alone at a table in the main dining room during the morning meal with no interaction with staff or other residents. b. Interview with the administrator on 5/23/17 at 3:22 PM revealed the resident had a feeding tube for his/her nutritional needs. The resident was taken to the dining room during meals times for socialization.	F 282		
F 322	483.25(g)(4)(5) NG TREATMENT/SERVICES -	F 322		

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F 322 SS=D	Continued From page 13 RESTORE EATING SKILLS (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and family interview, the facility failed to ensure a feeding tube was assessed for continued necessity for 1 of 9 sample residents (#6). The findings were: Review of the 3/7/17 quarterly MDS assessment showed resident #6 required extensive assistance with eating, was severely impaired for daily decision making, had a feeding tube, and was on a mechanically-altered diet. Review of the April 2017 recapitulation of physician orders showed the resident had diagnoses that included depression, diabetes, and failure to thrive. The	F 322	F322 Corrective action: Primary care physician ordered SLP evaluation and modified barium swallow study for Rt #6. Family requests for study to be conducted on 07/07/17 will schedule per family request. ID of others: Audit conducted on all residents past 30 days to determine if an SLP referral was initiated and not evaluated. Any residents identified as in need of evaluation will be seen by SLP. Systemic changes: Primary physician to review and evaluate need for SLP services and/or need for swallow/imaging studies quarterly for residents with enteral feeding. Monitoring: DNS/designee/physician to review results of barium swallow study for resident number 6. Results to guide current status. DNS to review physician's quarterly documentation. Results of audits to be taken to QAPI to determine frequency/duration of continuing audits.	6/25/17

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F 322	Continued From page 14 resident was on a regular soft diet with nectar-thickened liquids and pureed vegetable and fruit, with small portions. In addition, the resident had an order dated 9/16/15 for 5 cans of Isosource HN 1.2/250 ml (high protein tube-feeding formula) via the percutaneous endoscopic gastrostomy (PEG) tube. Review of the 4/26/17 nutritional assessment showed the resident ate food by mouth and also received 1500 calories from a tube feeding which was administered by bolus feedings 5 times per day. Review of the previous 3/29/17 nutrition assessment showed the resident had poor PO (by mouth) intake and ate in the assisted dining room for encouragement to consume meals and feed self. Review of the medical record showed the resident had the PEG tube prior to admission to the facility. Review of a hospital discharge summary dated 12/4/14 showed the tube was replaced in the hospital on 12/4/14, and the resident returned to the nursing home. The instructions were: "they [the facility] are to feed [the resident] as well as [s/he] is able to tolerate. They are to use the PEG tube for any additional feeding they think necessary." Review of physician orders from March 2014 to May 2017 showed the amount of the tube feedings had increased over time due to poor oral intake. There were also physician orders on 2/27/17 and 5/8/17 that showed the tube was replaced and/or dislodged. The following concerns were identified: a. Review of the medical record showed the last time the resident was evaluated for swallowing was on 12/23/14. Review of the recommendations showed "continue [with] nectar thick liquids mechanical soft chopped foods [with] extra gravies and thickened broth and the like. Puree vegetables. May have rice [with] added moisture."	F 322		

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F 322	Continued From page 15 b. Review of the 12/8/16 physician progress note showed the resident "is eating well, outside food (+ thickened)." There was no mention of the tube feeding and the plan was to continue the current care. Review of the 3/2/17 physician progress note showed the feeding tube became dislodged and it was replaced at the bedside with no difficulty. c. Review of a 2/26/17 physician order showed the resident's PEG tube was replaced at the hospital. Review of a 5/8/17 physician order showed the nursing staff could re-insert the PEG tube as needed due to the resident's behavior of pulling the tube out. d. Review of the 4/26/17 nutrition assessment note failed to include the level of assistance the resident required for eating and failed to include the monitored percent intake of food or calories the resident took by mouth. Review of the 3/29/17 nutrition assessment showed the resident required the tube feeding because PO intake remained inadequate. Further the assessment note showed "Alb [albumin] remains low from 11/14/16." e. Observation on 5/21/17 at 1:04 PM showed the resident was seated at a non-assisted table in the main dining room. S/he was served a soft/pureed meal of meatloaf, potatoes, broccoli and bread. During the observation, the resident made no attempt to eat any of the food. At 1:34 PM the resident continued to sit without eating and no encouragement or assistance had been provided by the staff during the meal observation. f. Interview with the resident's family on 5/23/17 at 2:22 PM revealed the resident had a preference for food from his/her country of origin and did not like "American" food. The family said they had "begged" the facility to allow the resident	F 322		

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F 322	Continued From page 16 to have foods that made him/her "happy." g. Interview with the MDS coordinator and the administrator on 5/23/17 at 3:22 PM revealed the resident had the tube feeding since before admission. The administrator stated the reasoning for the tube feeding was due to poor intake and failure to thrive. According to the MDS coordinator, the resident's family visited weekly and when they brought in the resident's preferred food the resident ate well "often 100%." She further revealed the resident's family had been educated on the risks of providing non-pureed foods. h. Review of a nurse's note dated 3/17/17 at 6:30 PM showed, "[Family] brought resident homemade meal - resident smiling eating." i. Review of the medical record and the diet card failed to show any food preferences for the resident. Additionally, the medical record failed to show any attempt to taper or discontinue the tube feeding. j. Review of the 4/26/17 care plan related to tube feeding showed there were no details for when and how the tube feeding was to be administered other than "as ordered by physician." The reason for the tube feeding was shown to be abnormal lab values, cognitive issues, and obesity (the resident's BMI was overweight at 29). The plan also failed to address when or if the tube feedings should be held due to the resident eating by mouth. In addition, the 4/26/17 nutrition and tube feeding care plans failed to address the resident's preference for non-texture-modified food and food brought in by the family. k. Interview with the CDM on 5/24/17 at 1:09 PM verified the resident enjoyed and ate the food the family brought in. She further verified she was unable to locate any documentation as to the	F 322		

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F 322	Continued From page 17 resident's food preferences. She stated these questionnaires were usually done on admission and as needed.	F 322		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure safety interventions were implemented to reduce aspiration risk for 1 of 2 sample residents (#16) who were at risk for aspiration. The findings were:	F 323	F323 Corrective action: DNS/Designee immediate staff training for positioning for resident #16 during oral intake. ID of others: DNS DNS/Designee to conduct audit to validate that residents were positioned in the correct angle while receiving PO intake. Systemic Changes: DNS/Designee care plans and care cards were updated to reflect need for 45 degree angle during oral intake for residents in tilt in space/Geri wheelchairs. Care plans for residents requiring use of tilt in space/Geri chairs will be reviewed 14 days post admission, quarterly and as needed. Reeducation of all clinical staff was completed by the SDC in regards to correct positioning for residents while receiving PO intake. Monitoring: DNS/Designee to conduct five times per week spot check on resident #16, three times a week for other residents in tilt-in-space/Geri chairs during times of PO intake for 45 degree positioning. Results to be taken to QAPI to determine need for frequency/duration of monitoring.	6/25/17

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F 323	Continued From page 18 Review of the 3/16/17 admission MDS assessment showed resident #16 required extensive assistance with eating. The resident had total dependence for assistance with all additional ADLs and was severely impaired in daily decision making. Review of a Speech Language Pathologist (SLP) progress note dated 3/27/17 at 1 PM showed the recommended positioning of the resident's upper body was at a 45 degree angle for eating and drinking. Review of the resident's care plan updated 5/8/17 related to nutrition and hydration showed the resident was totally dependent for eating and drinking, and required aspiration precautions. However, the care plan failed to include positioning of the resident at a 45 degree angle as recommended by the SLP. The following concerns were identified: a. Observation on 5/21/17 at 12 PM showed the resident was assisted by CNA #1 in the assisted dining room. The resident was reclined in a specialty geriatric wheelchair. The resident's upper body was positioned approximately at a 20 to 25 degree angle. The resident periodically coughed when s/he was fed and provided fluids. b. Interview with CNA #1 on 5/21/17 at 1:23 PM revealed she was unaware of the resident for recommended positioning of eating. Interview with RN #3 on 5/21/17 at 1:23 PM revealed the resident was reclined further than was indicated for eating and drinking. The RN helped the CNA raise the position of the back of the resident's chair for the remainder of the meal.	F 323		
F 327 SS=D	483.25(g)(2) SUFFICIENT FLUID TO MAINTAIN HYDRATION (g) Assisted nutrition and hydration.	F 327	F327 Corrective action: DNS/Designee bedside table was moved to be in reach of resident #30, staff training was immediately conducted concerning hydration and keeping resident's fluids within reach. RD assessed resident in regards to fluid intake needs. Care plan updated concerning fluid intake needs.	6/25/17

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F 327	Continued From page 19 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (2) Is offered sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview the facility failed to ensure interventions and monitoring were implemented to provide adequate hydration for 1 of 6 sample residents (#30) at risk for dehydration. The findings were: 1. Review of the 4/6/17 quarterly MDS assessment showed resident #30 had diagnoses which included hypertension, diabetes mellitus, and depression. The resident was coded as independent with setup only for eating but required extensive physical assistance with bed mobility and transfers. The resident had a recorded weight of 188 pounds (85.3 kilograms); and a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. Review of the initial nutrition evaluation dated 10/12/16 showed the estimated fluid intake section was left blank. Review of the April 2017 physician order recapitulation showed the resident was prescribed Lasix (a diuretic) 22 milligrams (mg) daily for edema on 10/12/16. The following concerns were identified: a. Review of the May 2017 meal monitor flowsheet from 5/1 through 5/12 showed a pattern of refused fluids (7 meals), unrecorded fluid intake (12 meals) and illegible numbers (3	F 327	ID of others: Audit of residents while in their room has been conducted to validate that their hydration was within reach. Systemic changes: DNS/Designee random audit will be conducted three times a week to ensure all residents have their water within reach. Meal monitor flowsheets audited three times a week to ensure PO intake documented as appropriate. Monitoring: DNS/Designee results from audits to be taken to QAPI to determine need for frequency/duration of monitoring.	

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F 327	Continued From page 20 meals). The recorded amount of fluid consumed was no greater than 480 ml total for any day during this timeframe. b. Review of a nurse's note dated 5/12/17 and timed 3:35 AM revealed two separate observations (11 PM and 2 AM) of a blood spot in the resident's incontinence briefs. c. On 5/12/17 an order for IV fluids for 3 days was received from the physician with a diagnosis of fluid deficiency. d. Review of a nurse's note dated 5/14/17 and timed 3:15 PM showed the IV came out and staff were unable to restart the IV after several attempts. An order to have the IV fluids discontinued was received from the physician on 5/14/17. e. Further review of the May 2017 meal monitor flowsheet from 5/13 through 5/21 showed a continued pattern of refusals (5 meals) and unrecorded fluid intake (10 meals). The recorded amount of fluid consumed was no greater than 560 ml total for any day during this timeframe. f. Review of a nurse's note dated 5/20/17 and timed 12:25 PM revealed the resident was taken by ambulance to the emergency room. Review of the hospital patient education summary showed the hospital diagnosed a urinary tract infection (UTI).Review of the nurse's note dated 5/20/17 and timed at 10:40 PM showed the resident returned to the facility at 6:40 PM on the same day. g. Observation on 5/21/17 at 5:50 PM showed the resident was in his/her bed. The bedside table, with a water jug on it, was located on the far side of the fall mat and out of reach of the resident. The resident was heard from the hallway calling out, "Anyone in the hallway? I can't reach my water jug." At 6 PM the administrator went into the room to check on the resident.	F 327		

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F 327	Continued From page 21 Continued observation showed neither the water jug nor the bedside table were moved, and the water remained out of the resident's reach. h. Review of the "Nutrition Hydration Status" care plan last updated on 5/9/17 showed no interventions were in place to observe the resident for signs and symptoms of dehydration or to offer fluids between meals. i. According to CD-HCF Dietetic Practice Group, Niedert K, Dorner B. Nutrition Care of the Older Adult. 2nd ed. Chicago, IL; American Dietetic Association; 2005, "Normal fluid needs are 25-30 mL of fluid/kg of actual body weight (ABW)." Based on the resident's weight in kg (85) the resident's estimated fluid needs for a day would be 2125-2550 ml (milliliters). 2. Interview on 5/23/17 at 3:50 PM with the CDM revealed the CNAs and HAs usually record the meal intake amounts after the meal service. She reviewed the flowsheets on a quarterly basis and further verified there were gaps in the documentation. 3. Interview on 5/23/17 at 4:45 PM with the DNS revealed all resident's water jugs were refilled 3 times a day, but the amount of fluid consumed was not recorded. The DNS agreed the documentation on the food and fluid monitoring flowsheets was lacking.	F 327		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater;	F 332	F332 Corrective action: DNS/Designee resident #30 medications reviewed, medications identified Celexa, Prilo-sec and K-Tab have been changed to medications for which crushing or dissolving are not contraindicated.	6/25/17

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F 332	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview and review of Prescribers' Digital Reference (PDR) dated 2017, the facility failed to ensure a medication error rate of five percent or less. The error rate for medication administration pass was 3 of 25 opportunities (12 percent). The findings were: 1. On 5/22/17 at 7:54 AM RN #1 crushed 11 medications and mixed the medications in a small amount of applesauce and gave the medications to resident #30. Among the medications crushed were: citalopram 20 milligrams (mg), omeprazole capsule 20 mg, and potassium 10 milliequivalent (mEq). Review of the PDR showed administration warnings for these 3 medications as follows: a. Citalopram (Celexa) may be taken with or without water or food, however, do not chew, break, or split the tablets. b. Omeprazole (Prilosec) Capsules should not be chewed or crushed. c. Potassium (K-tab) do not crush or chew. Do not allow to dissolve in the mouth. May be broken in half. 2. Review of the resident's MAR and the bubble packs for these medications showed no warnings in regard to altering the form of medications. 3. Review of physician orders showed there was no order to crush medications for the resident. 4. Interview on 5/24/17 at 10:44 AM with the administrator revealed the facility had a "Do Not Crush list" in the medication room and in front of each MAR. Review of the document showed it	F 332	ID of others: DNS/Designee conducted an audit and "Do Not Crush" has been added to the MAR for those medications that cannot be crushed. Systemic changes: DNS/Designee nurses have been educated on "do not crush" medications and any medication which is not to be crushed will have a warning added to the MAR. Monitoring: DNS/Designee to conduct random three times a week audit observing medication administration. Results will be taken to QAPI to determine need for frequency of monitoring.	

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F 332	Continued From page 23 was copyrighted in 2013 and included Prilosec and K-tabs as medications that were not to be crushed. The administrator went on to state that some nurses would not know what medications could not be crushed.	F 332		
F 353 SS=E	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 353	F353 Corrective action: DNS/Designee initiation of 1800 to 2200 second nurse to assist with completion of medication administration/resident care needs. ID of others: An audit has been conducted to validate that medications are given within the appropriate time frame. Systemic Changes: DNS/Designee audits to monitor completion of medication administration and timeliness of resident cares two times a week between the hours of 1800-2200. Staff have been educated on appropriate time frames for medication pass. Monitoring: DNS/Designee continuation of need of a second nurse after 1800 to be determined by audit results taken to QAPI to determine need for frequency/duration of monitoring.	6/25/17

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F 353	Continued From page 24 (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family, and staff interview and review of the staffing schedule, the facility failed to ensure nurse staffing was adequate to meet resident needs for evening medications. The census was 40. The findings were: 1. Review of the nursing schedules for May 1 through May 24, 2017 showed there was 1 licensed nurse assigned to the PM shift (6 PM to 6 AM). This nurse was responsible for the administration of medication and to provide needed nursing care to 40 residents for the shift. The following concerns were identified: a. Interview with a group of 10 residents on 5/22/17 at 1 PM revealed they were concerned about the nurse staffing at night. 4 of the 10 residents voiced a concern about medications not being received on time. One resident stated it was harder for residents to get medications on time because there was only one nurse working. b. Interview on 5/22/17 at 4:30 PM with	F 353		

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F 353	Continued From page 25 resident #14 revealed s/he was a diabetic and required insulin before bed. S/he stated before the facility changed the nursing schedule s/he received insulin around 8:30 PM and now that the facility only had one nurse at night s/he didn't get his/her insulin until sometime between 9:30 PM and 11:30 PM. The resident explained that the nurse started medication administration in the front hall and worked her way to the back hall. In addition, staff brought a snack at 6 PM, but sometimes s/he had to wait until 12 AM before it could be consumed because s/he had to wait for his/her blood sugar to be obtained. Review of the 3/9/17 quarterly MDS assessment showed the resident had a BIMS (brief interview for mental status) score of 14/15 (cognitively intact). c. Interview with RN #1 on 5/22/17 at 6:10 PM revealed the facility reduced staffing to 1 nurse at night around 6 weeks previously, and the residents were not getting their medications when they should. She stated she had heard concerns about residents getting their medications as late as midnight. d. Observation on 5/22/17 at 8:07 PM showed there was one licensed nurse working the 6 PM to 6 AM shift, and she was administering medications. e. Interview with RN #2 on 5/22/17 at 8:21 PM stated the medication pass was not done in a timely manner. "Medications cannot be passed if there was death, a fall, a blocked foley because those have to come first." The nurse confirmed the HS (bedtime) medication pass did not get done by 10 PM. f. Interview with the family of resident #37 on 5/22/17 at 8:18 PM revealed they were concerned there was only 1 licensed nurse on duty for the night shift. They stated one nurse was not enough to provide for the needs of the residents.	F 353		

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F 353	Continued From page 26 They also felt there was not enough staff at night to assist residents to the toilet and to bed in a timely manner. g. Interview with the DNS and administrator on 5/24/17 at 10:35 AM revealed they had gone to staffing one licensed nurse for the overnight shift "about 2 months ago." They were unable to budget for another full shift and none of the nurses were interested in working a partial shift. The DNS and the administrator stated they had received a grievance from a resident the previous night regarding timing of medications.	F 353		
F 356 SS=B	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census.	F 356	F356 Corrective action: DNS/Designee Actual hours worked were added to the facility posting sheet, the facility posting sheet was moved down 18" to be more prominently visible. ID of others: DNS/Designee No others identified. Systemic Changes: DNS/Designee nurses educated on the requirement to total hours on the posted nurse staffing data sheet. Sheets validated by DNS/ Designee. Monitoring: DNS/Designee to review staff posting for completion five times a week. Results to be taken to QAPI to determine need for frequency/duration of monitoring.	6/25/17

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F 356	Continued From page 27 (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of daily staff postings, the facility failed to ensure the nurse staff posting met all required elements for 13 of 14 days reviewed. The finding were: 1. Observation of daily nurse staff postings on 5/21/17 through 5/24/17 showed the facility failed to include the actual hours worked for "Licensed" and "Certified" nursing staff. In addition, the observation of the postings showed it was a regular letter-sized sheet of paper posted on the wall near the front lobby at a height of 6 feet. Due to the size and the height of the posting, it was not in a prominent place where it was visible to	F 356		

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F 356	Continued From page 28 those in wheelchairs. 2. Interview with administrator on 5/24/17 at 10:49 AM confirmed the facility failed to include the actual hours worked.	F 356		
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 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	F 441	F441 Corrective action: Infection control nurse/designee In-service to staff on appropriate hand washing/hygiene with an emphasis on hand hygiene during meal service. ID of others: Infection control nurse/designee Random audit of hand hygiene/ hand washing 3-5 times per week. Systemic changes: Infection control nurse/designee to increase hand hygiene in- services to quarterly. Monitoring: Infection control nurse/designee Results of audits to be taken to QAPI to determine frequency/duration of continuing audits.	6/25/17

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F 441	Continued From page 29 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. (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, staff interview, and policy review, the facility failed to ensure infection prevention practices were implemented during 2 meal observations. The findings were:	F 441		

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F 441	Continued From page 30 1. Observation of the noon meal on 5/21/17 at 1:17 PM in the assisted dining area showed CNA #1 was spoon feeding a male resident with her right hand. She then turned and used the same hand to feed and assist another resident without performing hand hygiene. 2. Observation of the evening meal on 5/21/17 at 6:02 PM in the assisted dining area showed the therapy manager touched 4 different residents without performing hand hygiene between them. She was observed handling different resident's silverware, after the resident had been using them, to cut up their food. 3. Review of the policy published in May 2015 titled "Hand Hygiene" showed staff were expected to use an alcohol-based hand rub containing at least 62% alcohol, or alternatively, soap (antimicrobial or non-antimicrobial) and water for situations which included: "...before and after eating or handling food...before and after assisting a resident with meals." 4. Interview with the infection control nurse on 5/23/17 at 11:14 AM confirmed staff were expected to clean their hands between resident contact and as needed.	F 441		
F 465 SS=D	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465	F465 Corrective action: Maintenance manager/designee. Screen door on back/kitchen entrance has been repaired. East wall has been painted and peg board removed. Cove base near walk in refrigerator replaced. Baseboard heater has been repaired and painted.	6/25/17

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F 465	Continued From page 31 (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure the environment in the kitchen was maintained in a sanitary condition. The findings were: 1. Observation on 5/23/17 at 12:16 PM showed the kitchen required the following repair work: a. The screen door of the back entrance had damaged areas on the bottom half with paint chipping off. The east wall in this area was also damaged; the wall was peg board with chipped and peeling paint. The wall was also bowed and flexible when pressed on. b. A 5 foot section of cove base was missing from the wall near the walk-in refrigerator. This exposed a non-cleanable surface. c. The base board heater located in the kitchen, near the entrance, under the dish window had chipped paint and rusted areas. 2. Interview with the dietary manager on 5/23/17 at 2:15 PM verified these areas needed to be repaired. She stated maintenance would be able to answer questions related to any schedules for the work to be done. Interview with the maintenance director on 5/24/17 at 10:20 AM confirmed the repair of these items would need to be scheduled.	F 465	ID of others: Maintenance manager/designee. Ceiling in kitchen identified in need of paint, no other areas identified. Systemic changes: Maintenance manager/designee. All staff education in-service on use of maintenance forms, identification of areas of concern/need of repair. Areas identified during environmental rounds to be added to maintenance schedule for repair. Monitoring: Maintenance manager/designee to conduct environmental rounds, results to be taken to QAPI to determine need for frequency/duration of monitoring.	
F 468 SS=D	483.90(i)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS	F 468	F468 Corrective action: Maintenance manager/designee. Handrails identified as loose across from rooms 19 and 4 were both tightened/secured.	6/25/17

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F 468	Continued From page 32 (i)(3) Equip corridors with firmly secured handrails on each side; and This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure corridors were equipped with firmly secured handrails in 2 of 3 hallways (front, middle). The findings were: 1. Observation on 5/23/17 at 10:30 AM showed the handrail located in the middle hallway across from the activity office and down from resident room #19 was loose from the wall. 2. Observation on 5/23/17 at 11:05 AM showed the handrail located in the front hallway across from resident room #4 was loose from the wall. 3. Interview on 5/24/17 at 9:15 AM with the maintenance manager confirmed the handrails were loose and needed to be tightened.	F 468	ID of others: Maintenance manager/designee. Handrails throughout building were checked no others identified. Systemic changes: Maintenance manager/designee. All staff education in-service on use of maintenance forms, identification of areas of concern/need of repair. Areas identified during environmental rounds to be added to maintenance schedule for repair. Monitoring: Maintenance Manager/designee to conduct environmental rounds, results to be taken to QAPI to determine need for frequency/duration of monitoring.	