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

PRINTED: 09/14/2017
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
	535056	A. BUILDING _____ B. WING _____	C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE VIEW CARE CENTER	1325 SAGE STREET ROCK SPRINGS, WY 82901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 8/27/17 through 8/30/17. Also reviewed in the course of this survey were complaint intakes WY000002401 and WY000002416. The following common abbreviations are used throughout this document: ADLs: Activities of Daily Living ARD: Assessment Reference Date CAA: Care Area Assessment CNA: Certified Nurse Aide DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse LPN: Licensed Practical Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	DISCLAIMER CLAUSE PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLEY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW.	
F 156 SS=B	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he	F 156	F-156 Corrective action – Signs have been posted with contact information for appropriate state agencies as identified and with statement to inform resident that they may file a complaint with the State Survey Agency. ID of others- No other required need for postings identified. Systemic changes- Required postings as identified will remain posted, ED educated on required state forms to be posted in center. Monitoring- n/a	9/27/17

ATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE NHA | (X6) DATE 9/23/17

...iciency-statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ...afeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ...g 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 ...llowing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ...participation.

SEP 29 2017

9/27/17 Plan of Correction accepted.

Healthcare Licensing and Surveys

NHA, Naomi King, notified on 9/28/17 at 1:48PM.
team Mimi

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F 156	Continued From page 1 or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.	F 156		

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F 156	Continued From page 2 (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the	F 156		

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F 156	Continued From page 3 facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	F 156		

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F 156	Continued From page 4 (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.	F 156		

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F 156	Continued From page 5 (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of	F 156		

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F 156	Continued From page 6 these regulations. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to post the required notices in a form and manner accessible to residents and resident representatives. The census was 46. The findings were: Observation of the facility during the survey timeframe showed the names, addresses (mailing and email), and phone numbers of all pertinent State agencies and advocacy groups and the required statement to inform residents they may file a complaint with the State Survey Agency or request information with regard to returning to the community was not available. Interview with the administrator on 8/29/17 at 4 PM verified the absence of the required postings.	F 156		
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) 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.	F 164	F-164 Corrective action- DNS/ designee to educate Aides involved on resident privacy. ID of others- DNS/designee will conduct random 3x week audits to ensure resident's privacy during cares is maintained. Systemic changes- DNS/ designee will provide education to all clinical staff on privacy during cares. Monitoring- Results of audits will be taken to QAPI to determine need for duration of monitoring.	9/27/17

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F 164	Continued From page 7 §483.70 (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 provide privacy during personal care for 1 non-sample resident (#33) who required assistance with toileting. The findings were: Observation on 8/28/17 at 9:14 PM showed resident #33 was assisted to the bathroom by CNA #1 and CNA #2. The resident was helped into the bathroom, his/her pants were removed, and upon completion, perineal care was provided. During care, the bathroom door was left open and	F 164		

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F 164	Continued From page 8 the privacy curtain was not pulled. Further observation showed the resident's roommate was in bed but awake during the care, and s/he watched the care provided to resident #33. Interview with CNA #1 on 8/28/17 at 10:14 PM revealed she "forgot" to pull the curtain and confirmed privacy should be given during care. Interview with the administrator and DON on 8/29/17 at 11:30 AM revealed the facility's expectation was for staff to provide privacy by closing doors and pulling curtains during care.	F 164		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(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 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	F 225	F-225 Corrective action- Resident to Resident altercation identified as occurring 5/9/17 has been reported as a late report. ID of others- NHA/ designee will conduct an audit of reportable events for the past 3 months to determine if any other reports were not submitted. Any reports with lack of proof of reporting will be reported. Systemic changes- ED educated on reporting requirements Monitoring- All state reportable events will be reviewed at QAPI. Proof of reporting will be provided and reviewed.	9/27/17

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F 225	Continued From page 9 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. (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 review of facility investigation	F 225		

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F 226	Continued From page 10 documentation, facility policies and procedures, State Agency incident report log, and staff interview the facility failed to report an allegation of abuse to the State Survey Agency for 1 of 3 allegations (involving resident #37, #38) reviewed. The findings were: 1. Review of facility investigation documentation revealed an alleged incident of resident to resident physical abuse involving resident #37 and #38 occurred on 5/9/17. 2. Review of the State Agency incident report log for May 2017 showed no evidence the allegation was reported as required. 3. Interview with the administrator on 8/30/17 at 9:15 AM revealed she was not the administrator at the time of the incident and was unable to locate any documentation to confirm the incident had been reported. 4. Review of the facility's policy "Abuse, Neglect, Exploitation, and Misappropriation of Resident Property Prohibition", updated March 2017, revealed "7. b....The Center reports allegations and substantiated occurrences of abuse, neglect, exploitation, misappropriation of property, or injuries of unknown source to the state survey and certification agency..."	F 226		
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	F 244	F-244 Corrective action- Grievances identified as having not been written from resident council May and June have been written and submitted. ID of others- ED/ designee will review previous resident council grievances for past three months with	9/27/17

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F 244	Continued From page 11 the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (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 review of resident council meeting minutes and resident and staff interview, the facility failed to ensure grievances from the resident council were acted upon and followed through to resolution for 3 of 3 months reviewed (May 2017, June 2017, July 2017). The findings were: 1. Review of the resident council minutes for May 2017 and June 2017 showed concerns were discussed related to the flavor and temperature of the food. The following concerns were identified: a. Interview with 9 residents on 8/28/17 at 11 AM revealed there had been no response from the facility in regard to the grievance made about the food in both May and June 2017. b. Review of the June 2017 and July 2017 resident council minutes in the section "Old Business" showed the section was left blank. c. Interview with the activities director on 8/29/17 at 8:56 AM revealed if a concern was discussed at a resident council meeting and the residents agreed, a grievance form was filled out and given to the social worker, the appropriate department manager, and/or the administrator to follow-up on. After the concern was resolved the grievance form was returned to her and then	F 244	resident council members to determine if any grievances have not been reported or followed up on from resident council. Any identified grievances will be submitted. Systemic Changes- DNS/ designee will provide education to staff on grievance policy Monitoring- All grievances will be reviewed at standup meeting.	

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	535056	A. BUILDING _____ B. WING _____	C 08/30/2017

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F 244	Continued From page 12 discussed with the residents at the next council meeting. In addition, she would note in the section of "Old Business" how many grievances had been discussed and have the residents initial the grievance form. d. Interview with the social worker on 8/29/17 at 11:05 AM revealed no grievance about the food was documented on her log sheet. e. Interview with the activities director on 8/30/17 at 3 PM verified there was no evidence the grievance had been followed through to resolution in regard to the concern about the food.	F 244		
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 1 of 4 resident hallways (400) were clean and in good repair. The findings were: 1. Observation of room 418 on 8/29/17 at 9:50 AM showed the inner bathroom door frame had an area that measured 36 inches up from the floor which was damaged and exposed the underlying metal. The heater vent in the bathroom had a bracket that was bent outward and exposed a sharp edge. The inside of the bathroom door had a scraped area 5 1/2 inches up from the floor that measured 19 inches across the door and exposed the underlying wood. Further, the door had a hole 7 inches up from the floor and 12 inches in from the edge that	F 253	F-253 Corrective action-Identified Door frames, Doors, heater vent and base coves from room 418, 415 and 412 have been repaired. ID of others- Maintenance Director /designee- Door frames, Doors, heater vent and base coves will be audited to identify if any others show signs of disrepair. Any identified areas of concern will be repaired/ replaced as appropriate. Systemic Changes- Maintenance Director will be educated on "Other Environmental conditions" as outlined in State operation manual. Monitoring- Door frames will be audited weekly during environmental rounds. Results of audits will be taken to QAPI to determine ongoing frequency of monitoring.	9/27/17

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F 253	Continued From page 13 measured 5 inches by 3 inches and a second hole 4 inches up from the floor and 1 inch from the first hole that measured 4 1/2 inches by 3/4 inches. The outer door frame had an area that measured 25 inches up from the floor that was damaged and exposed the underlying metal. The base cove on the outside of the bathroom had pulled away and had accumulated dirt and debris behind it. The damaged areas created surfaces which could not be cleaned effectively. 2. Observation of room 415 on 8/29/17 at 2:30 PM showed the bottom right corner of the inner kickplate had pulled away and was folded outward. The outer door frame had an area that measured 30 inches up from the floor which was damaged and exposed the underlying metal. The damaged areas created surfaces which could not be cleaned effectively. 3. Observation of room 412 on 8/29/17 at 2:42 . PM showed the inner bathroom door had a hole 11 inches up from the floor and 9 inches in from the edge which measured 2 inches by 4 inches. The damaged area created a surface which could not be cleaned effectively. 4. Interview with the maintenance director on 8/30/17 at 9 AM revealed the facility had identified 7 damaged doors; however, replacement doors had not been ordered at that time. Further, it was revealed he was not aware of the damaged door frames and confirmed they could not be cleaned effectively.	F 253		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments	F 272	F- 272 Corrective action- Identified residents have had assessments completed to MDS with additional information added to the CAA section	9/27/17

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F 272	Continued From page 14 (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 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.	F 272	ID of others- An audit will be performed on MDS assessments completed over the last month to determine if any other residents did not have CAA adequately completed. Any residents identified will have a modification completed. Systemic Changes- Education provided to MDS Coordinator and Reviewing nurses on the CAA requirements. Monitoring- CAA will be reviewed prior to submission by DNS designee for completion. Results of audits will be reviewed at QAPI to determine ongoing frequency of audits.	

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F 272	Continued From page 15 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, staff interview, and review of the CMS RAI version 3.0 manual, the facility failed to ensure the comprehensive assessment of resident needs in a variety of areas for 6 of 7 sample residents (#3, #9, #10, #16, #39, #40). The findings were: 1. Review of the 5/17/17 significant change MDS assessment for resident #3 showed the following areas triggered and required a comprehensive assessment: cognitive loss, communication, urinary incontinence, falls, nutritional status, dehydration, pressure ulcers, and psychotropic drug use. Review of the CAAs for these triggered areas showed they were incomplete, were not individualized to the care area, and lacked an analysis of the data to support the care plan decision. 2. Review of the 7/11/17 annual MDS assessment for resident #9 showed the following areas triggered and required a comprehensive assessment: cognitive loss, visual function, ADL functional/rehabilitation potential, urinary incontinence, psychosocial well-being, falls, nutritional status, dental care, and pressure ulcers. Review of the CAAs for these triggered areas showed they were incomplete, were not individualized to the care area, and lacked an analysis of the data to support the care plan decision.	F 272		

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F 272	Continued From page 16 3. Review of the 1/10/17 significant change MDS assessment for resident #10 showed the following areas triggered and required a comprehensive assessment: cognitive loss/dementia, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, psychosocial well-being, mood state, activities, falls, nutritional status, dehydration, pressure ulcer, psychotropic drug use, and pain. Review of the CAAs showed a thorough and individualized analysis of data to support the care plan decision was lacking for the following triggered areas: urinary incontinence and indwelling catheter, activities, falls, nutritional status, dehydration, pressure ulcer, psychotropic drug use, and pain. 4. Review of the 7/3/17 annual MDS assessment for resident #16 showed the following areas triggered which required a comprehensive assessment: cognitive loss/dementia, communication, urinary incontinence, psychosocial well being, mood state, falls, nutritional status, pressure ulcers, and psychotropic medication use. Review of the CAAs for these triggered areas showed they were incomplete and lacked a thorough analysis of the data to support the care plan decision. 5. Review of the 6/1/17 annual MDS assessment for resident #39 showed the following areas triggered and required a comprehensive assessment: delirium, cognitive loss, visual function, communication, urinary incontinence, psychosocial well-being, falls, nutritional status, dental care, pressure ulcers, and pain. Review of the CAAs showed a thorough and individualized analysis of data to support the care plan decision	F 272		

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F 272	Continued From page 17 was lacking for the following triggered areas: visual function, communication, urinary incontinence, falls, dental care, pressure ulcer, and pain. 6. Review of the 5/2/17 annual MDS assessment for resident #40 showed the following areas triggered which required a comprehensive assessment: cognitive loss/dementia, communication, urinary incontinence, falls, nutritional status, dental care, pressure ulcers, and psychotropic medication use. Review of the CAAs for these triggered areas showed they were not individualized to the specific care area, and lacked a thorough analysis of the data to support the care plan decision. 7. Interview with the MDS coordinator on 8/30/17 at 10 AM revealed the CAA identified what each resident triggered for and without an individualized analysis of the care areas, the facility could not develop an individualized and thorough care plan. Further, it was confirmed that the analyses of the care areas for the identified residents were not individualized. 8. According to the CMS RAI version 3.0 manual "...The completed MDS must be analyzed and combined with other relevant information to develop an individualized care plan. To help nursing facilities apply assessment data collected on the MDS, Care Area Assessments (CAAs) are triggered responses to items coded on the MDS specific to a resident's possible problems, needs or strengths...The CAAs reflect conditions, symptoms, and other areas of concern that are common in nursing home residents and are commonly identified or suggested by MDS findings. Interpreting and addressing the care	F 272		

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F 272	Continued From page 18 areas identified by the CATs is the basis of the Care Area Assessment process, and can help provide additional information for the development of an individualized care plan."	F 272		
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 (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	F-278 Corrective action- Modifications have been made to identified residents #3 and #10 section M of MDS and resubmitted. ID of others- DNS/ Designee will review MDS section M for the previous 3 months to determine if any other errors were present. Any errors found will have a MDS modification submitted. Systemic Changes- Education provided in accordance with RAI manual for section M to MDS nurse, DNS, ED and MDS review nurse on MDS accuracy Monitoring- MDS will be reviewed by DNS/ RN prior to submission for accuracy. Results of review will by taken to QAPI to determine ongoing monitoring.	9/27/17

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F 278	Continued From page 19 (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the CMS RAI version 3.0 manual, the facility failed to ensure MDS assessments were accurately completed for 2 of 7 sample residents (#3, #10) reviewed. The findings were: 1. Review of the significant change MDS assessment with an ARD of 3/13/17 revealed resident #3 was at risk for pressure ulcers and was coded as having no unhealed pressure ulcers or current pressure ulcers. In addition, the resident was coded as having no other ulcers, wounds, or skin problems. Review of the significant change MDS assessment with an ARD of 5/17/17 showed the resident was at risk for pressure ulcers and was coded as having no unhealed pressure ulcers, current pressure ulcers, or other skin problems. Review of the quarterly MDS assessment with an ARD of 8/10/17 showed the resident was at risk for pressure ulcers and was coded as having no unhealed pressure ulcers, current pressure ulcers, or other skin problems. The following concerns were identified: a. Review of a nurse's note dated 2/26/17 showed the resident had a new open area to the right buttock. Further review of nurse's notes dated 3/8/17 through 8/8/17 showed the resident had an open area to the coccyx/sacral area that was being monitored and dressed. b. Review of the "Weekly Skin Evaluation" dated 3/15/17 through 5/15/17 showed the resident had an open area to the buttocks that was being monitored. In addition, review of the "Weekly Skin Evaluation" dated 5/2/17 through	F 278		

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F 278	Continued From page 20 6/27/17 showed an area to the left knee that was being monitored. 2. Review of the 12/13/16 quarterly MDS assessment for resident #10 showed the resident had one stage 2 pressure ulcer with the date of the oldest recorded as 11/28/16. Review of the "Pressure Ulcer Care Plan" initiated on 11/28/16 and last revised on 8/18/17 showed the resident had a stage 2 pressure ulcer on the sacrum. Further review showed treatment was ongoing with no evidence the pressure ulcer had resolved. The following concerns were identified: a. Review of the 1/10/17 significant change MDS assessment showed the resident had one stage 2 pressure ulcer with the date of the oldest pressure ulcer in section M0300B3 dashed, which indicated the date was unknown. Section M0900A (Were pressure ulcers present on the prior assessment?) was left blank. b. Review of the 3/31/17 quarterly MDS assessment showed the resident had one stage 2 pressure ulcer with the date of the oldest pressure ulcer dashed. c. Review of the 6/15/17 quarterly MDS assessment showed the resident had one stage 2 pressure ulcer with the date of the oldest pressure ulcer dashed. Section M0300B2 (Number of stage 2 pressure ulcers present at admit/reentry) was coded as 1. Review of the medical record revealed the resident was readmitted to the facility from the hospital on 1/3/17. 3. Interview with the MDS coordinator on 8/30/17 at 10:15 AM confirmed the skin issues were not coded on the MDS assessments. Further, she stated, when she was aware of wounds, she gave the assessment to the RN to complete.	F 278		

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F 278	Continued From page 21 4. According to the CMS RAI version 3.0 manual section M0300B2 "...5. If a resident who has a pressure ulcer that was originally acquired in the facility is hospitalized and returns with that pressure ulcer at the same numerical stage, the pressure ulcer should not be coded as 'present on admission' because it was originally acquired at the facility prior to the hospitalization." Section M0300B3: "Enter the date of the oldest Stage 2 pressure ulcer. The facility should make every effort to determine the actual date that the Stage 2 pressure ulcer was first identified whether or not it was acquired in the facility..." Section M0900A: "...Enter 1: if there were pressure ulcers noted on the prior 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 includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the	F 279	F-279 Corrective action- resident identified as #6 has had care plans reviewed and updated for fall occurring 6/28/17, including addition of interventions as appropriate. ID of others- An audit will be conducted on all active residents for needed care plan reviews/ updates/ additional interventions. Identified care plans will be reviewed/ updated. Systemic Changes- Education will be provided to licensed nurses on care plans. Care plans will be reviewed by IDT team with 14 day MDS assessment and quarterly with the MDS schedule Monitoring- Results of audits will be reviewed at QAPI to determine frequency continuing care plan audits	9/27/17

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F 279	Continued From page 22 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 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 279		

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F 279	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on medical record review, fall review documentation, and staff interview, the facility failed to ensure a comprehensive care plan with meaningful interventions was developed based on resident needs for 1 of 7 sample residents (#6). The findings were: Review of the 8/7/17 quarterly MDS assessment for resident #6 showed the resident had diagnoses which included hypertension, diabetes mellitus, depression, schizophrenia, unspecified pulmonary disease, hypothyroidism and migraine. The resident required the limited assistance of 1 staff member for locomotion. Review of the June 2017 physician order recapitulation revealed the resident was prescribed medications for diabetes, hypertension, depression, schizoaffective disorder, diabetes neuropathy, chronic pain, and hypothyroidism. Review of a nurse's note dated 6/28/17 showed the resident had tripped in the bathroom and fell hitting his/her head on the heat register and landed on his/her right side. The resident was taken to the emergency department for evaluation. Review of the Interdisciplinary Team (IDT) fall review dated 6/28/17 showed the root cause of the fall was the resident was not using his/her walker in the bathroom and lost balance. Contributing factors marked were "Medical Status/Physical Condition/Diagnoses" and "Toileting status." There was no documentation of an investigation to determine what caused the resident to lose his/her balance. It was the recommendation of the team to have PT (physical therapy) screen the resident and the care plan was updated. Review of the "Fall Risk Care Plan" last revised 6/29/17 showed no evidence interventions were developed or	F 279		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535056	A. BUILDING _____ B. WING _____	C 08/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE VIEW CARE CENTER	1325 SAGE STREET ROCK SPRINGS, WY 82901

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F 279	Continued From page 24 implemented after the fall. Interview with the MDS coordinator and the administrator on 8/30/17 at 10:10 AM confirmed the care plan was not updated to show interventions after the fall.	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, staff interview, and medical record review, the facility failed to follow care plans for 2 of 7 sample residents (#16, #40) who required assistance with toileting, positioning, and oral care. The findings were: 1. Review of the 7/3/17 annual MDS assessment showed the resident had diagnoses that included non-Alzheimer's dementia, depression, overactive bladder, and urinary incontinence. Further review showed the resident required extensive assistance of 1 person for transfers, dressing, toilet use, and personal hygiene, was frequently incontinent of bladder, and occasionally incontinent of bowel. Review of the "Self-care Deficit" care plan last revised 3/28/17 showed the resident required staff to provide "Oral care BID [twice per day] and PRN [as needed]." Review of the "Fall Risk" care plan last revised on 7/30/17 showed "Resident toileting schedule: Q [every] two (2) hours." The following	F 282	F 282 Corrective action- Resident identified as # 16, 40 had oral exams completed with no adverse effects noted. Resident #40 had had skin exam preformed which was negative. Resident # 16 had care plan updated to reflect appropriate toileting status. ID of others: A random audit will be conducted on cares performed to ensure they are consistent with care plan. Care plans will be reviewed and updated as needed. Systemic Changes- Staff have been educated on care plan and providing care per care plan, C.N.A care cards will be moved to interior door of residents closets when appropriate for easier access for aides. Monitoring- DNS/ designee will conduct random 3x week audit to ensure care being provided is consistent with care plan. Results of audits will be reviewed at QAPI to determine ongoing frequency and monitoring.	9/27/17

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F 282	Continued From page 25 concerns were identified: a. Observation on 8/27/17 at 3:50 PM showed the resident was taken to the dining room, provided coffee, and placed at a dining table. Continued observation showed the resident was taken to his/her room at 6:10 PM, 2 hours and 20 minutes later, by CNA #3. The CNA assisted the resident with incontinence care, assisted the resident into pajamas, and assisted the resident into bed. Oral care was not offered or provided and toilet use was not offered during the care observation. 2. Review of the 7/24/17 quarterly MDS assessment showed resident #40 had diagnoses which included Alzheimer's disease, weakness, and anxiety disorder. Further review showed the resident required extensive assistance of 2 or more people for transfers, total assistance of 1 person for dressing, toilet use, and personal hygiene, and was frequently incontinent of bowel and bladder. Review of the "Dementia/Alzheimer's" care plan created on 7/27/17 showed the resident required staff to "Turn and reposition, Q [every] two (2) hours." Review of the "Self-care Deficit" care plan last revised 1/5/16 showed the resident required staff to provide "Oral care BID [twice per day] and PRN [as needed]." Review of the "Oral/Dental" care plan last revised 1/5/16 showed "Provide oral care at least BID [twice per day]." The following concerns were identified: a. Observation on 8/27/17 at 3:50 PM showed the resident was taken out of his/her room and placed in the sitting area near the nurse's station. Continued observation showed the resident was taken to the dining room at 4:15 PM where the resident remained until 6:40 PM, 2 hours and 50 minutes later, when the resident	F 282		

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F 282	Continued From page 26 was taken back to the sitting room. The resident was not repositioned during that time. b. Observation on 8/27/17 at 6:50 PM showed the resident was taken to his/her room by CNA #4. The CNA assisted the resident to change into a gown and provided incontinence care. No oral care was performed or offered. 3. Interview with the administrator, DON, and regional nurse on 8/29/17 at 11:30 AM revealed the facility expected staff to follow the care plan when providing care to residents.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is	F 309	F-309 Corrective action- MD/ family of Resident #6 were notified of incomplete neuro assessments. Resident chart reviewed for evidence of adverse effects with none identified. ID of others-Unwitnessed falls or falls requiring neurological assessments over the past 3 months will be reviewed to determine any other discrepancies or lack of initiation. Residents/ families/ physicians will be notified as appropriate of any missing assessments/ adverse results. Systemic Changes- Education on neurological assessment policy will be provided to all nursing staff. Monitoring- Neurological assessments will be audited/ reviewed during clinical meeting to ensure neurological assessments were completed per policy. Results of audits will be presented at QAPI	9/17/17

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F 309	Continued From page 27 provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure neurological assessments were completed as necessary for 1 of 6 sample residents (#6) who experienced falls. The findings were: Review of a nurse's note dated 6/28/17 and timed 7:20 AM showed resident #6 had tripped in the bathroom, fallen, and hit his/her head on the heat register, and landed on his/her right side. The resident was taken to the emergency department for evaluation. Review of a nurse's note dated 6/28/17 and timed 3:15 PM revealed the resident had returned from the emergency department with a diagnosis of contusions to the head, hip and chest wall. Continued review showed no evidence neurological assessments were initiated after the resident returned to the facility. Interview with the administrator on 8/29/17 at 10:40 AM confirmed the neurological assessments were not completed as per policy. Review of the policy "Neurological Evaluation" updated September 2014 showed "In the event that a resident has a fall and it is suspected or	F 309		

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F 309	Continued From page 28 known that the resident has bumped/hit his/her head, neurological evaluations are initiated and continued for 24 hours and the resident is placed on alert charting for 72 hours....7. If the resident is transported to the hospital during the evaluation, the nurse resumes Neurological Evaluation Log upon return."	F 309		
F 312 SS=E	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to provide oral care for 2 of 7 sample residents (#16, #40) and 2 non-sample residents (#16, #33) who required assistance with activities of daily living. The findings were: 1. Review of the 7/3/17 annual MDS assessment showed resident #16 had diagnoses that included non-Alzheimer's dementia, and required extensive assistance of 1 person for personal hygiene. Review of the "Self-care Deficit" care plan last revised 3/28/17 showed the resident required staff to provide "Oral care BID [twice per day] and PRN [as needed]." The following concerns were identified: a. Observation on 8/27/17 at 6:10 PM showed CNA #3 assisted the resident with incontinence care, assisted the resident into pajamas, then assisted the resident into bed. Oral care was not offered or provided.	F 312	F-312 Corrective action-Residents identified as # 16, 40, 18 and 33 have had oral assessment completed per nursing without evidence of adverse effects noted. ID of others- An initial 100% audit on oral care evaluations to determine any other oral care concerns will be completed. Any identified residents will have dental referrals made as appropriate Systemic Changes- Licensed staff will be educated on offering/ providing oral cares. Monitoring- DNS/ designee will conduct 3x week audit to ensure oral care is being offered/ provided. Results of audits will be reviewed at QAPI for determination of frequency of audits	9/27/17

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F 312	Continued From page 29 2. Review of the 7/24/17 quarterly MDS assessment showed resident #40 had diagnoses which included Alzheimer's disease and the resident required total assistance of 1 person for personal hygiene. Review of the "Self-care Deficit" care plan last revised 1/5/16 showed the resident required staff to provide "Oral care BID [twice per day] and PRN [as needed]." Review of the "Oral/Dental" care plan last revised 1/5/16 showed "Provide oral care at least BID [twice per day]." The following concerns were identified: a. Observation on 8/27/17 at 6:50 PM showed the resident was taken to his/her room by CNA #4. The CNA assisted the resident to change into a gown, provided incontinence care, and then assisted the resident to bed. No oral care was performed or offered at that time. 3. Observation on 8/28/17 at 9:35 PM showed CNA #1 and CNA #2 took resident #33 to his/her room and assisted the resident to bed. No oral care was offered or provided at that time. 4. Observation on 8/28/17 at 9:50 PM showed CNA #1 and CNA #2 took resident #18 to his/her room and assisted the resident to bed. No oral care was offered or provided at that time. 5. Interview with CNA #1 on 8/28/17 at 10:14 PM revealed oral care should be provided residents when they were assisted to bed; however, she stated she forgot to provide it. 6. Interview with the administrator, DON, and regional nurse on 8/29/17 at 11:30 AM revealed the facility expected oral care to be performed or offered during HS [hour of sleep] care.	F 312		
F 315	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI,	F 315		

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F 315 SS=D	Continued From page 30 RESTORE BLADDER (a) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 315	F-315 Corrective action- Residents identified as # 16 and #40 have been assessed for ability to direct toilet as well as for evidence of skin breakdown. No skin issues identified. Care plans were reviewed and updated. ID of others- All residents be assessed for ability to direct toilet and will have care plan reviewed for appropriate approach, care plans will be updated/ revised as appropriate. Systemic Changes- Education provided to staff on providing toileting care as determined in the care plan. Monitoring-- DNS/ designee will conduct a random 3x week audit to determine if toileting needs are being provided as outlined in the care plan. Results of audits will be reviewed at QAPI for continued frequency of audits.	9/27/17

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F 315	Continued From page 31 Based on observation, staff interview, medical record review, and policy and procedure, the facility failed to ensure timely toileting or incontinence care was provided to 2 of 7 sample residents (#16, #40) who required toileting assistance. The findings were: 1. Review of the 7/3/17 annual MDS assessment showed resident #16 had diagnoses that included non-Alzheimer's dementia, depression, overactive bladder, and urinary incontinence. Further review showed the resident required extensive assistance of 1 person for transfers, dressing, toilet use, and personal hygiene, was frequently incontinent of bladder, and occasionally incontinent of bowel. Review of the "Fall Risk" care plan last revised on 7/30/17 showed: "Resident toileting schedule: Q [every] two (2) hours." The following concerns were identified: a. Observation on 8/27/17 at 3:50 PM showed the resident was taken to the dining room, provided coffee, and placed at a dining table. Continued observation showed the resident was taken to his/her room at 6:10 PM, 2 hours and 20 minutes later, by CNA #3. The CNA assisted the resident with incontinence care, assisted the resident into pajamas, and assisted the resident into bed. The resident was not offered to use the bathroom at that time.	F 315		
	2. Review of the 7/24/17 quarterly MDS assessment showed resident #40 had diagnoses which included Alzheimer's disease, weakness, and anxiety disorder. Further review showed the resident required extensive assistance of 2 or more people for transfers, total assistance of 1 person for dressing, toilet use, and personal hygiene, and was frequently incontinent of bowel			

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F 315	Continued From page 32 and bladder. The following concerns were identified: a. Observation on 8/27/17 at 3:50 PM showed the resident was taken out of his/her room and placed in the sitting area near the nurse's station. Continued observation showed the resident was taken to the dining room at 4:15 PM where the resident remained until 6:40 PM, 2 hours and 50 minutes later, when the resident was taken back to the sitting room. The resident was not offered to use the bathroom during that time. b. Observation on 8/27/17 at 6:50 PM showed the resident was taken to his/her room by CNA #4. The CNA assisted the resident to change into a gown and provided incontinence care. The resident was not offered to use the bathroom at that time. 3. Interview with the administrator, DON, and regional nurse on 8/29/17 at 11:30 AM revealed the facility expected staff to follow the care plan when providing care to residents. Further, it was revealed the facility does not have a set time frame when residents should be toileted; however, residents should be taken to the bathroom before meals, after meals, and as needed. 4. Review of the policy and procedure titled "Alteration in Elimination" last updated July 2014 showed "...Each resident is evaluated for bowel and bladder incontinence. Procedure: At admission, the nurse completes the Nursing Admission Evaluation. a. Residents identified as incontinent of bladder have the Bladder Evaluation completed. b. Residents identified as incontinent of bowel have the Bowel Evaluation completed. 2. Incontinent residents who are	F 315		

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F 315	Continued From page 33 comatose, unable to safely sit on the toilet or bedpan due to physical impairments, exhibit agitated behaviors, or are traumatized by staff-directed toileting procedures are managed with incontinence products. 3. Residents who resist or refuse bowel and bladder training have the risks and benefits of their choices explained and documented, and their rights and wishes respected. 4. If a bowel and/or bladder toileting/retraining program is indicated, create an individualized toileting program for the resident to assist in keeping the resident optimally continent. 5. Appropriate and individualized care plan interventions are implemented when the evaluation is completed."	F 315		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used– (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 329	F-329 Corrective action- Residents identified as # 16 and 40 have had behavior monitoring flowsheets created and placed MAR. ID of others- All residents on psychoactive medications will be audited to ensure behavior monitor flow sheet tool is in place. Any residents identified as not having tool in use will have it added to MAR for tracking. Systemic Changes- Education will be provided to Social Services Director as well as LN staff on the Behavior Monitor tracking flowsheets. Monitoring- SSD/ designee will audit Q month to ensure behavior monitor flowsheets are in use for those residents on qualifying psychoactive medications. Results will be taken to QAPI.	9/27/17

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F 329	Continued From page 34 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure behavior monitoring was performed for 2 of 3 sample residents (#16, #40) who received psychotropic medications. The findings were: 1. Review of the 7/3/17 annual MDS assessment showed resident #16 had diagnoses which included depression, non-Alzheimer's dementia, and altered mental status. Further review showed the resident had a BIMS (brief interview for mental status) score of 0 (severely impaired), a depression score of 11 (moderate), and no identified behaviors. Review of the July 2017 physician order sheet showed the resident had an order for fluoxetine 40 mg [milligrams] by mouth every AM for major depressive disorder and lorazepam 0.5 mg by mouth three times per day for restlessness and agitation. The following concerns were identified:	F 329		

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F 329	Continued From page 35 a. Review of the medical record showed no evidence the facility was tracking resident-specific behaviors to evaluate the effectiveness of the medications. 2. Review of the 7/24/17 quarterly MDS assessment showed resident #40 had diagnoses which included Alzheimer's disease and anxiety disorder. Further review showed the resident had a BIMS score of 3 (severely impaired), a depression score of 3 (minimal), and no identified behaviors. Review of the July 2017 physician order sheet showed the resident received buspirone 5 mg by mouth two times per day for anxiety disorder and Ativan 0.5 mg by mouth one time per day as needed for anxiety state. The following concerns were identified: a. Review of the medical record showed no evidence the facility was tracking resident-specific behaviors to evaluate the effectiveness of the medications. 3. Interview with the DON on 8/28/17 at 3:60 PM revealed the facility did not have any behavior monitoring for resident #16 or resident #40. 4. Review of the policy titled "Psychoactive Drugs" last updated 11/16 showed "...5. Prior to initiating any psychoactive drug, the IDT [interdisciplinary team]: a. Reviews the medical record, PHQ9 and Brief Interview for Mental Status (BIMS) on MDS, Behavior Monitoring Flowsheet, progress notes, and evaluations related to behavior..."	F 329		
F 371 SS=E	483.60(l)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (l)(1) - Procure food from sources approved or	F 371	F371 Corrective action- kitchen microwave was cleaned, cutting board identified as red, brown and green have been replaced	9/27/17

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	535056	A. BUILDING _____ B. WING _____	C 08/30/2017

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F 371	Continued From page 36 considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure food was prepared under sanitary conditions in 1 of 1 kitchens. The findings were: Observation on 8/27/17 at 1:15 PM and again on 8/28/17 at 3:10 PM showed the interior of the kitchen microwave was soiled with food build-up and needed to be cleaned. Continued observation at 3:10 PM showed the red, brown, and green cutting boards were visibly scored which created a surface which could not be cleaned. Interview with the dietary manager at that time confirmed the microwave needed to be cleaned and the	F 371	ID of others- All cutting will be checked for excessive wear, and replace any identified equipment that could pose risk as an uncleanable surface. No other microwaves in kitchen use. Systemic Changes- Dietary Manager will add microwave to daily rounds, Education provided to CDM on kitchen equipment condition and identifying need for replacement Monitoring- CDM/designee will audit equipment for condition every week. Results will be taken to QAPI to determine need for continued frequency of monitoring.	

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F 371	Continued From page 37 cutting boards needed to be replaced. According to Food Code 2013, U.S. Public Health Service 4-501.12 "Surfaces such as cutting blocks and boards that are subject to scratching and scoring shall be resurfaced if they can no longer be effectively cleaned and SANITIZED or discarded if they are not capable of being resurfaced." According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."	F 371		
F 387 SS=E	483.30(c)(1)(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT (c) Frequency of Physician Visits (1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure physician visits were completed every 60 days for 6 of 11 sample residents (#2, #6, #9, #16, #39, #40). The findings were:	F 387	F-387 Corrective action- Residents # 2, 9, 16, 39 and 40. Have been seen by primary care physicians. Resident #6 is within 60 visit range at this time. An appointment had been scheduled for her next visit to be within appropriate time frame. ID of others- audit has been conducted to identify any residents exceeding 60 days between visits. All identified residents have had physician visit or appointment made for visit	9/27/17

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F 387	Continued From page 38 1. Review of the medical record for resident #2 showed the resident was seen by a physician on 1/13/17. The next physician visit was on 4/21/17 (98 days). The next documented physician visit was on 7/14/17 (84 days) with no mid-level practitioner visits between. 2. Review of the medical record for resident #6 showed the resident was seen by a physician on 1/13/17. The next physician visit was on 4/7/17 (81 days). The next documented physician visit was on 7/24/17 (108 days) with no mid-level practitioner visits between. 3. Review of the medical record for resident #9 showed dates of physician visits included 9/28/16, 12/27/16, 3/21/17, 5/15/17, and 8/4/17. Further review showed there were no additional visits from 9/28/16 through 12/27/16 (90 days). In addition, there were no documented visits from 12/27/16 through 3/21/17 (84 days) and 5/15/17 through 8/4/17 (81 days). 4. Review of the medical record for resident #16 showed the resident was seen by a physician on 11/22/16 and was not seen again until 3/29/17, 123 days later. Further review of the medical record showed no evidence of any physician visits between 3/29/17 and 8/30/17 (154 days). 5. Review of the medical record for resident #39 showed the resident was seen by a physician on 11/22/16. The resident was then seen by a mid-level practitioner on 3/29/17 (127 days). There was no evidence the resident had been seen by a physician since the 11/22/16 visit. 6. Review of the medical record for resident #40	F 387	Systemic Changes- Education provided to scheduler as well as Medical Director on 60 day requirement. Physician visits will be reviewed monthly to determine upcoming need for visits each month. Monitoring- Medical Records/ designee will audit charts Q month to ensure visits are provided in a timely manner. Results will be reviewed at QAPI.	

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F 387	Continued From page 39 showed the resident was seen by a physician on 1/13/17 and was not seen again until 4/21/17, 98 days later. Further, the subsequent visit after 4/21/17 was dated 7/14/17, 84 days later. 7. Interview with the administrator on 8/30/17 at 10:16 AM confirmed physician visits should have been completed more frequently.	F 387		
F 467 SS=E	483.90(l)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC (l)(2) Be well ventilated; This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure the ventilation system was functioning correctly in 3 of 4 resident hallways (100, 300, 400). The findings were: 1. Observation during the initial tour on 8/27/17 at 1:20 PM showed the 100 hallway, which was located in the secure unit, smelled of urine near room 104. 2. Observation on 8/29/17 at 9:10 AM showed the 100 hallway continued to have a urine odor outside of room 104. 3. Observation on 8/29/17 between 9:10 AM and 9:40 AM showed the vents in rooms 102, 104, 105, 304, 305, 401, and 406 were not working. The function of the ventilation was confirmed with use of a tissue held against the ventilation cover. 4. Interview with the maintenance director on 8/30/17 at 8:53 AM revealed the ventilation had been worked on recently and he was not aware the vents were not functioning. The maintenance	F 467	F-467 Corrective action- ventilation systems have been repaired in the 100, 300 and 400 hallways. ID of others- All other exhaust fan motors have been have been checked to ensure function Systemic Changes- Education provided to Maintenance Director on need for appropriate ventilation in center. Monitoring- Ventilation system will be checked Q week for proper function. Results will be taken to QAPI to determine need for frequency of continued monitoring.	9/27/17

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F 467	Continued From page 40 director confirmed the ventilation was not working and the lack of function was not related to a blown breaker.	F 467		
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic	F 514	F-514 Corrective action- Residents identified as #3, 9, and 16 have been assessed for any adverse effects- with no noted adverse effects- from noted holes in blood pressure and/or 02 levels on MAR. ID of others- Vital signs to be listed on MARs for past 3 months will be audited for completion. Residents with missing information will be assessed for adverse effects and families and physicians will be notified as appropriate of any adverse side effects. Systemic Changes- Education will be provided to nursing staff on completion of the MAR. Monitoring- DNS designee will audit for completion of documentation in the MAR 3x week. Results will be taken to QAPI to determine continued frequency of monitoring.	9/27/17

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F 514	Continued From page 41 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure medical records were complete and accurate for 3 of 7 sample residents (#3, #9, #16). The findings were: 1. Review of the 8/10/17 quarterly MDS assessment showed resident #3 had diagnoses that included hypertension and hypoxemia. Further the assessment showed the resident utilized oxygen. Review of a 3/6/17 physician order showed the resident was prescribed hydrochlorithiazide (HCTZ) 25 milligrams (mg) once daily and lisinopril 2.5 mg daily for hypertension. In addition, the order for lisinopril showed it was to be held if the systolic blood pressure (SBP) was less than 130. The following concerns were identified: a. Review of the June and July 2017 treatment administration record (TAR) showed the nurse was to titrate oxygen to maintain oxygen saturation twice per day (8 AM and 8 PM). In addition, the nurse was to document the liters per minute (LPM) and pulse oximeter results. Review of the resident's TAR from 6/1/17 through 6/30/17 showed the LPM was not recorded on 10 shifts. In addition, the pulse oximeter results were not recorded on 15 shifts. Review of the resident's TAR from 7/1/17 through 7/31/17 showed the LPM was not recorded on 12 shifts. In addition, the pulse oximeter results were not recorded on 27 shifts. b. Review of the July 2017 medication administration record (MAR) showed a blood pressure was to be obtained at the 8 AM HCTZ 25 mg and lisinopril 2.5 mg medication	F 514		

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F 514	Continued From page 42 administration. In addition, instructions included the lisinopril was to be held if the SBP was less than 130. Review of the resident's MAR from 7/1/17 through 7/31/17 showed no evidence a daily blood pressure reading was recorded for the HCTZ. Continued review showed no evidence a blood pressure reading was recorded on 29 shifts for the lisinopril. c. Review of the August 2017 MAR showed a blood pressure was to be obtained at the 8 AM HCTZ 25 mg and lisinopril 2.5 mg medication administration. Review of the resident's MAR from 8/1/17 through 8/28/17 showed no evidence a blood pressure reading was recorded on 14 shifts for the HCTZ. Further review showed no evidence a blood pressure reading was recorded on 16 shifts for the lisinopril. 2. Review of the 7/11/17 annual MDS assessment showed resident #9 had diagnoses that included hypertension and shortness of breath. In addition, the assessment showed the resident utilized oxygen. The following concerns were identified: a. Review of the May, June, and July 2017 MAR showed the nurse was to titrate oxygen to keep oxygen saturation greater than 90% and document the oxygen saturation twice per day. In addition, instructions included notifying the physician of saturations less than 90%. Review of the resident's MAR from 5/1/17 through 5/31/17 showed no saturation result recorded on 13 shifts. Review of the resident's MAR from 6/1/17 through 6/30/17 showed no saturation results recorded on 7 shifts. Review of the resident's MAR from 7/1/17 through 7/31/17 showed no saturation result recorded on 14 shifts. b. Review of the August 2017 MAR showed the resident was to have blood pressure obtained	F 514		

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F 514	Continued From page 43	F 514		

twice per day. In addition, instructions included notifying the physician if SBP was lower than 120. Review of the resident's MAR from 8/1/17 through 8/29/17 showed a blood pressure was not recorded on 20 shifts.

3. Review of the 7/3/17 quarterly MDS assessment showed resident #16 had diagnoses that included hypertension. Review of a 7/27/17 physician order sheet showed the resident was prescribed amlodipine 10 milligrams (mg) once daily and lisinopril 10 mg twice daily for hypertension. The following concerns were identified:

a. Review of the July 2017 medication administration record (MAR) showed a blood pressure was to be obtained at the 8 AM and 8 PM lisinopril medication administration. In addition, the order for lisinopril showed it was to be held if the systolic blood pressure was less than 100 or the diastolic blood pressure was less than 60. Further review showed the blood pressure was not recorded on 28 out of 31 days at 8 AM and 4 out of 31 days at 8 PM during July 2017.

b. Review of the June 2017 MAR showed a blood pressure was to be obtained at the 8 AM and 8 PM lisinopril medication administration. In addition, the order for lisinopril showed it was to be held if the systolic blood pressure was less than 100 or the diastolic blood pressure was less than 60. Further review showed the blood pressure was not recorded on 28 out of 30 days at 8 AM and 8 out of 30 days at 8 PM, during June 2017.

c. Review of the May 2017 MAR showed a blood pressure was to be obtained at the 8 AM and 8 PM lisinopril medication administration. In addition, the order for lisinopril showed it was to

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F 514	Continued From page 44 be held if the systolic blood pressure was less than 100 or the diastolic blood pressure was less than 60. Further review showed the blood pressure was not recorded on 27 out of 31 days at 8 AM and 3 out of 31 days at 8 PM during May 2017. 4. Interview with the DON on 8/30/17 at 10:15 AM confirmed the records were incomplete. Further, she revealed her expectation was for blood pressures and oxygen saturations to be documented on the MARs and TARs. In addition, she stated she expected the nurses to hold blood pressure medications if the reading was outside the ordered parameters.	F 514		