STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING _____ B. WING _____	C 11/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY HEALTHCARE CENTER	60 MAGNOLIA CASPER, WY 82604

(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 the Office of Healthcare Licensing and Surveys on 11/13/17 through 11/16/17. Also reviewed in the course of the survey were complaint intakes WY00002513, WY00002508, WY00002504, WY00002482, WY00002478, WY00002473, WY00002468. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living BIMS- Brief Interview for Mental Status CNA- Certified Nurse Aide DON- Director of Nursing Services LPN- Licensed Practical Nurse MDS- Minimum Data Set MAR- Medication Administration Record RN- Registered Nurse TAR- Treatment Administration Record Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 166 SS=B	RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES CFR(s): 483.10(j)(2)-(4) (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy	F 166		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: NHA | (X6) DATE: 12/11/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

POC accepted with agreed upon changes
& Mike Speidel on 12/21/17

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F 166	Continued From page 1 to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident	F 166	**RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES** **Corrective Actions** The Resident Council was informed on 12/6/17, by the Director of Nursing (DON) of the right to file Grievances and Concerns: • Orally • Written • Anonymously • Grievance Official is Mandi DeLeon, Activities Director; 307-234-9381, ext. 104 • Expected time frame for resolution and notification • Right to receive written decision regarding concerns or grievances • Independent entities where concerns or grievances may be files. • Posting of grievance process and official. • The facility will send a letter to residents and Resident Representatives on "how to use/fill out a grievance." **Others Potentially Affected** All residents have the potential to be affected by this practice. **Systemic Changes** 1) Resident Council informed of rights related to grievances and concerns on 12/6/17. 2) Department Head Team and all staff will be educated on or before 12/29/17, regarding the process and resident rights related to grievances or concerns.	12/29/17

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F 166	Continued From page 2 right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, review of policy and procedure, and staff interview, the facility failed to	F 166	**Monitoring** Monthly audit of grievance and concern resolution will be completed by the SSD/designee and reported to the QAPI Committee. The QAPI Committee will analyze for trends and areas of improvement. Auditing will continue until the QAPI Committee determines that compliance has been met and sustained.	

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F 166	Continued From page 3 ensure a grievance posting with the required information. The census was 170. The findings were: Review of the "Grievance/Concern" policy last revised 11/2016 showed there was to be a posting which contained information related to the right to file grievances orally or in writing, the right to file grievances anonymously, the contact information of the grievance official, the expected time frame for completing a review of grievances, the resident's right to receive a written decision regarding concern/grievance, and contact information of independent entities with whom grievances may be filed, that is, the pertinent State Agency; Quality Improvement Organization; State Survey Agency and State LTC Ombudsman program. The following concerns were identified: a. Observation on 11/16/17 at 9 AM showed there were grievance forms available in holders on the wall in various areas of the facility. However, there was no posting related to filing grievances including the use of the forms, or how to submit them. b. Interview with the director of nursing on 11/16/17 at 5:04 PM confirmed the policy was consistent with the requirements; however, it was not implemented.	F 166		
F 241 SS=E	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced	F 241		

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F 241	Continued From page 4 by: Based on observation, medical record review, review of bathing documentation, and resident and staff interview, the facility failed to promote quality of life for 4 random residents (#3, #68, #69, #105). The findings were: 1. Review of the 8/31/17 quarterly MDS assessment showed resident #3 required extensive assistance with bathing and was cognitively intact with a BIMS score of 15. Interview with the resident on 11/14/17 at 5:21 PM revealed the resident made an appointment with a CNA to have a bath or shower at 5 PM. The resident was upset because the staff member did not show up, and there was no one available to help him/her. The resident stated there was not enough help to get a bath or shower more than once per week and sometimes it was longer. S/he stated it made him/her feel "deflated" and "scared to go around other people" because of "not being clean." Review of the bathing/shower documentation provided for October and November 2017 showed there were no refusals noted, the resident was bathed on 10/11/17, 10/20/17, 10/26/17, 10/30/17 and 11/16/17. 2. Interview on 11/13/17 at 3:31 PM during initial facility tour revealed resident #105 felt s/he had to wait a long time for help, stating staff "answer the call light and say they will be back". This caused him/her to wait longer for help with activities of daily living, which included assistance transferring to bed and using the bathroom. Observation on 11/14/17 at 7:04 PM showed the resident's call light was on. An unidentified staff member entered the room at 7:06 PM, turned off the call light, and left the room. The resident stated in an	F 241	DIGNITY AND RESPECT OF INDIVIDUALITY Corrective Actions Res #105 no longer resides at the facility. Res #3, #68, and #69 are receiving bath/shower twice weekly. Res #68 is provided with a "shampoo shower cap" in between bathing, when the resident feels their hair is oily. Facility staff are responding to resident call lights in a timely fashion and completing tasks as indicated by priority of needs. Others Potentially Affected All residents have the potential to be affected by this practice. Systemic Changes Nursing staff will be educated by the SDC/designee, on or before 12/29/17, on resident Quality of Life, resident preferences, meeting resident needs, bathing and personal hygiene, including timely answering of call lights. Monitoring Audits will be performed weekly, by the Unit Managers/designee on each unit, on resident bathing completion per resident preference, personal hygiene, and call light response/resolution times. Audit findings will be reported to the QAPI Committee monthly for analysis and recommendations until the committee determines compliance has been met and sustained.	12/29/17

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F 241	Continued From page 5 interview at 7:11 PM the staff member told him/her that they would be back to help. Continued observation showed at 7:15 PM the call light was turned on again and a staff member entered the room. From the hallway the staff member was heard stating they had a new admission. The light was turned off and the staff member left the room. At 7:17 PM the call light was again turned on. At 7:18 PM the call light was turned off, and at 7:20 PM the resident's door was closed with staff in the room. 3. Review of the 10/26/17 annual MDS assessment showed resident #68 did not have cognitive impairment and had functional limitation in range of motion in both legs. Review of the care plan, revised on 11/8/17, showed the resident required extensive assistance with personal hygiene and bathing due to muscle weakness. During an interview on 11/13/17 at 3:30 PM, the resident stated sometimes s/he did not receive a shower for 7 to 10 days and this caused his/her hair to become "extremely oily." The resident further stated, "It feels awful to have to be around other people when my hair is so oily." Review of the bathing/shower records showed the resident did not receive a bath/shower from 10/12/17 to 10/19/17 (7 days), from 10/24/17 to 10/31/17 (7 days), and from 11/7/17 to 11/14/17 (7 days). 4. Interview on 11/16/17 at 12:40 PM with resident #69 revealed s/he wanted a shower two times a week and only got one a week. S/he stated this had been going on for two months. The resident further stated s/he had talked with the nurse manager and filled out a grievance and stated "It makes me feel like I'm not important."	F 241		

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F 241	Continued From page 6 5. Interview with the DON on 11/14/17 at 3:47 PM verified there were staff shortages of CNAs and licensed nurses. The DON provided data that showed as of 10/31/17 there were 8 full-time and 1 part-time positions for CNAs that were vacant and 8 full-time nurse positions which were vacant. She also stated there were currently 7 CNAs who were on light work duty and 1 bath aide who was out on a medical leave. The DON stated they were actively hiring and had bonus incentives in place. She was aware the length of time to have call lights answered was extended, and bathing and restorative services were not being provided as planned due to these staff shortages.	F 241		
F 253 SS=D	HOUSEKEEPING & MAINTENANCE SERVICES CFR(s): 483.10(i)(2) (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 provide maintenance services to maintain a sanitary environment for 2 of 5 dining/snack areas (Krampert unit dining room, ice cream shop). The findings were: 1. Observation on 11/15/17 at 4:02 PM of the dining room in the Krampert unit showed there were twenty 12 inch by 12 inch floor tiles that had gouges in them, which created a surface which could not be cleaned effectively. 2. Observation on 11/15/17 at 4:30 PM of the ice cream shop showed a bench with a vinyl-type covering which was cracked in 5 areas, exposing the underlying cushion fabric. The cracks	F 253	HOUSEKEEPING & MAINTENANCE SERVICES Corrective Actions The gouged tiles in the Krampert dining room were replaced. The vinyl bench seat in the Ice Cream Parlor has been removed and discarded. Others Potentially Affected All residents have the potential to be affected by this practice. A walking audit of facility common areas will be completed to identify any potential surfaces in poor repair. Concerns identified in the audit will be corrected immediately if possible; or scheduled for repair as soon as possible. Systemic Changes All staff education will be completed on or before 12/29/17, regarding maintaining a sanitary, orderly, and comfortable interior for the residents, including documentation of identified concerns in the maintenance log for repair or replacement. Environmental services will be re-educated on daily review of the maintenance log and timely completion of areas identified; and timely repair of concerns identified through routine EVS department rounds.	12/29/17

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F 253	Continued From page 7 measured 11 inches by 7 inches, 4 inches by 6 inches, 4 inches by 1 inch, 7 inches by 1/2 inch, and 3 inches by 1/2 inch. The cracks created a surface which could not be cleaned effectively. 3. Interview on 11/16/17 at 11:35 AM with the Maintenance Director and Administrator while observing the two areas confirmed the floors and bench required maintenance.	F 253	Monitoring Weekly visual audit by Housekeeping/Maintenance to determine surfaces that are in poor repair or have an uncleanable surface. Audit findings will be reported to the QAPI Committee for analysis and recommendations. Audits will continue until the QAPI Committee has determined compliance has been met and sustained.	
F 274 SS=D	COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE CFR(s): 483.20(b)(2)(ii) (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 and staff interview, the facility failed to ensure a significant change MDS assessment was completed as required for 1 of 5 sample residents (#124) with significant changes. The findings were: Review of the 1/19/17 annual MDS assessment showed resident #124 was not at risk for developing pressure ulcers and the resident had no pressure ulcers or history of healed pressure	F 274	COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE Corrective Actions The significant change MDS assessment for resident #124 has been completed and reflects the resident's current status. Others Potentially Affected Any resident with a significant change have the potentially to be affected by this practice. Systemic Changes MDS Nurses will be educated by the Regional MDS Consultant regarding the criteria for a Significant Change and the timing for Significant Change assessment completion. Education will be completed on or before 12/29/17.	12/29/17

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F 274	Continued From page 8 ulcers. Review of additional MDS assessments showed the following concerns: a. The section for pressure ulcers on the 7/20/17 quarterly showed the resident had 2 stage 2 pressure ulcers with an onset date of 6/13/17. b. Review of the 10/19/17 quarterly MDS assessment showed the resident had 3 stage 2 pressure ulcers. c. Interview with MDS coordinators #1 and #2 on 11/16/17 at 1:15 PM revealed a significant change MDS assessment was required due to the development of the ulcers and had not been initiated.	F 274	**Monitoring** Weekly audit by MDS Coordinator for criteria of significant change assessment, on any resident identified by the IDT to ~~experience~~ meet criteria of a change of condition; encompassing each unit of the facility. Audit findings will be reported to the QAPI Committee monthly for analysis and recommendations, until the committee has determined that compliance has been met and sustained.	
F 278 SS=E	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (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-	F 278		

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F 278	Continued From page 9 (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 staff interview, medical record review, review of the Resident Assessment Instrument (RAI) Manual, and review of policy and procedure, the facility failed to ensure MDS assessment information was an accurate reflection of the resident's status for 8 of 26 sample residents (#2, #21, #49, #60, #105, #118, #147, #163). The findings were: 1. Review of the admission MDS assessment for resident #2, signed 8/27/17, showed the resident had a height of 63 inches. However, a significant change assessment, signed 9/18/17, revealed the section for height had been dashed, indicating information was not available. Further, the admission assessment documented the resident's pneumococcal vaccination as "not assessed." 2. Review of the admission MDS assessment for resident #21, signed 9/8/17, showed the resident's pneumococcal vaccination was documented as "not assessed."	F 278	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED Corrective Actions Resident #105 no longer resides at the facility. MDS assessments for residents #2, #21, #49, #60, #118, #147, and #163 have been modified to reflect current resident status of height, weight, and pneumococcal immunization. Others Potentially Affected All residents have the potential to be affected by this practice. Systemic Changes MDS Nurses and Licensed Nurses will be educated on or before 12/29/17 regarding accuracy of obtaining and documenting resident heights, weights, and pneumococcal immunizations. Monitoring Weekly audits by Unit Managers/designee of each unit, on new admission heights, weights and pneumococcal immunization data. Audit findings will be reported to the QAPI Committee monthly, for further analysis and recommendations, until the committee determines that compliance has been met and sustained.	12/29/17

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F 278	Continued From page 10 3. Review of the admission MDS assessment for resident #105, signed 10/17/17, revealed the section for weight had been dashed, indicating information was not available. Further, the assessment documented the resident's pneumococcal vaccination as "not assessed." 4. Review of the admission MDS assessment for resident #118, signed 7/18/17, showed the resident had a height of 75 inches. However, a quarterly assessment, signed 10/19/17, revealed the section for height had been dashed, indicating information was not available. Further the admission assessment section for weight had been dashed, indicating information was not available. The pneumococcal vaccination was marked as "not assessed" on both the admission and quarterly assessments. 5. Review of the 10/23/17 quarterly MDS assessment showed the pneumococcal vaccine was not up to date for resident #49, with no reason coded. 6. Review of the 8/21/17 quarterly MDS assessment for resident #163 showed no information was coded for influenza vaccine. Pneumococcal vaccine was coded as not being received, but no reason was coded. 7. Review of the 8/21/17 quarterly MDS assessment for resident #60 showed pneumococcal vaccine was coded as not being received, but no reason was coded. 8. Review of the Admission MDS dated 4/13/17 showed resident #147 did not have an admission weight recorded. Review of the 7/13/17 significant change MDS assessment and the 10/9/17	F 278		

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SHEPHERD OF THE VALLEY HEALTHCARE CENTER	60 MAGNOLIA CASPER, WY 82604

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F 278	Continued From page 11 quarterly MDS assessment showed the resident didn't have a height recorded. 9. Interview on 11/16/17 at 12:24 PM with the consultant dietitian revealed that the admission heights and weights were often collected from admission paperwork provided by the "referring facility", and did not reflect a height or weight that was assessed by the facility. She explained that was the reason resident #2 and #118 had a recorded height on the admission MDS assessment but not the quarterly assessment. She confirmed she was not able to find facility documentation for height for these residents. She further stated she was unable to find documentation regarding weight to record on the admission assessment for resident #118. She further stated when the facility staff had not assessed height or weight, she used referring facility data to assess nutrition risk. 10. Interview on 11/16/17 at 1:03 PM with MDS personnel RN #3 revealed that when there was no information in the resident's record regarding previous receipt of the pneumococcal vaccine, they marked the MDS section O-0300 A. as "not assessed." She further stated they didn't usually "have privy" to that information, and didn't attempt to gather the information from other sources, such as the resident's family, primary doctor or care provider. 11. Interview on 11/16/17 at 2 PM with the DON revealed it was the expectation that height and weight should be done on admission. She stated a height measure was available on each unit. She further stated weights should be done weekly for the first four weeks, then per doctor order. Further, she stated the admitting nurse was	F 278		

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F 278	Continued From page 12 responsible to "make sure weight and height were done." 12. Review of the facility policy "Pneumococcal Vaccination - Resident/Patient" showed the following procedure: "1. Newly admitted residents will be offered the pneumococcal vaccine (See ACIP guidelines for complete details) 2. Each resident's immunization status will be determined prior to vaccination, and will be documented in their individual medical record. 3. Signed, informed consent in the form of a discussion/education regarding risks and benefits will occur prior to vaccination. (This may be with their authorized representative when appropriate.) CDC Vaccination Information Sheet (VIS) will be reviewed with resident/representative also. 4. Residents may refuse vaccination. Vaccination refusal and reasons why (e.g., allergic, contraindicated, did not want vaccine, etc.) should be documented by the facility on the consent/declination form. 5. Vaccine administered at time of admission will be given according to the Standing Order: Pneumococcal vaccine upon admission to the facility unless it has already been received/or is medically contraindicated. 6. Re-vaccinations will be administered according to primary physician's order...." 13. Review of the facility policy "Height - Resident", effective 10/4/14 showed the following procedure: "1. Each resident will have their height measured at admission to the facility. If the resident cannot stand, a height will be taken using a head to toe tape measure process with the resident lying flat in bed. After admission, the	F 278		

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F 278	Continued From page 13 resident's height will be measured annually." 14. Review of the facility policy "Resident Weights", revised June 2015, showed the following: "1. Each resident will be weighed on the first week of each month. 2. The weights will be recorded in the facility Weight Book or in PCC [point click care software]. 3. Residents who have been identified by the ID Team as high risk will be weighed more often. For example, dialysis residents may be weighed daily or per a specific order. High nutrition risk residents may be required to be weighed weekly or per recommendation of Dietician. 4. Weights which occur more often than monthly will be recorded in medical record. 5. All weekly weights will be completed on a specific date or week, for instance on bath day, in order to provide facility consistency with this process. 6. Weights will be reviewed by the Dietary Manager and by the IDT." 15. Review of the CMS's Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.15, October 2017, showed the following: a. Step by step instructions for obtaining vaccine status information. The manual showed "If vaccination status cannot be determined, administer the appropriate vaccine to the resident, according to the standards of clinical practice." b. Steps for Assessment for K0200A, Height "1. Base height on the most recent height since the most recent admission/entry or reentry. Measure and record height in inches. 2. Measure	F 278		

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F 278	Continued From page 14 height consistently over time in accordance with the facility policy and procedure, which should reflect current standards of practice (shoes off, etc.). 3. For subsequent assessments, check the medical record. If the last height recorded was more than one year ago, measure and record the resident's height again." c. Steps for Assessment for K0200B, Weight: "1. Base weight on the most recent measure in the last 30 days. 2. Measure weight consistently over time in accordance with facility policy and procedure, which should reflect current standards of practice (shoes off, etc.). 3. For subsequent assessments, check the medical record and enter the weight taken within 30 days of the ARD of this assessment. 4. If the last recorded weight was taken more than 30 days prior to the ARD of this assessment or previous weight is not available, weigh the resident again. 5. If the resident's weight was taken more than once during the preceding month, record the most recent weight."	F 278		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the	F 280	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP Corrective Actions Resident #86 no longer resides at the facility. Others Potentially Affected Residents who have had an incident or accident have the potential to be affected by this practice.	12/29/17

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F 280	Continued From page 15 expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must– (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to– (A) The attending physician.	F 280	Systemic Changes Licensed Nurses will be educated by the SDC/designee on the requirement and process of updating care plans, on or before 12/29/17. Monitoring Weekly audits of 5 random residents on each unit by the Unit Manager/designee related to care plan updates for residents who have experienced an incident or accident. Audit findings will be reported to the QAPI Committee monthly for analysis and recommendations, until the committee determines compliance has been met and sustained.	

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F 280	Continued From page 16 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on medical record review, incident report review, and staff interview, the facility failed to revise the care plan for 1 of 25 sample residents (#86). The findings were: Review of the 10/31/17 change in condition progress note revealed resident #86 had developed a red and blistered area on his/her skin from spilled coffee. Review of the 10/31/17 incident report revealed the resident's skin was red and developed blisters after the coffee spill and s/he was transported to the ER. The incident	F 280		

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F 280	Continued From page 17 report further revealed the resident's care plan had been updated regarding the incident. Review of the care plan, last reviewed on 11/10/17, showed this area on skin and any risk for burns related to consuming hot liquids was not addressed. Interview with unit manager #1 on 11/16/17 at 9:20 AM confirmed the care plan was not updated regarding the incident and the interventions that were put in place.	F 280		
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (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 medical record review and staff interview, the facility failed to provide care in accordance with the written plan of care for 2 of 23 sample residents (#2, #147). The findings were: 1. Review of the care plan for resident #2, under the category of diet and eating, showed "I receive both enteral nutrition and a prescribed mechanically altered diet. I had a peg tube placed at the acute hospital. I have multiple dx [diagnoses] that may have a negative impact on my nutritional status including dysphasia, surgical site infection, HTN [hypertension] and DM [diabetes mellitus]. I have experienced a	F 282	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN Corrective Actions Resident #2 and #147 have their weight obtained and documented per physician's order and/or facility protocol. Others Potentially Affected Residents with special orders for more frequent weights than standard protocol have the potential to be affected. The DNS/designee reviewed physician's orders for weight monitoring to identify other residents potentially affected by the current practice. No further residents were identified. Systemic Changes Nursing staff will be educated by the SDC/designee, on or before 12/29/17, regarding obtaining resident weights per physician's order and/or facility protocol; including documenting weights accurately.	12/29/17

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F 282	Continued From page 18 significant weight loss from my original admission. I have experienced a lengthy hospitalization". The goal showed "I want to maintain my current weight +/ 3% (sic)." Interventions included "I need to [sic] weighed weekly", which was created and initiated on 9/13/17. The following concerns were identified: a. Review of the medical record "weights and vitals summary" showed the resident had an initial weight of 178.5 pounds (lbs), recorded on 8/18/17. The record showed two other weights, 155.7 lbs on 10/20/17, and 154.9 lbs on 11/12/17. The resident was not in the facility from the dates of 8/23/17 to 9/7/17, and 9/15/17 to 10/13/17. The facility was unable to provide evidence that weights were assessed for the weeks of 10/22/17, 10/29/17 and 11/5/17 while the resident was in the facility. b. Interview on 11/16/17 at 12:42 PM with the consultant dietitian confirmed she had put the weekly weights intervention on the care plan, stating it was standard on "this unit" (Krampert) to do weekly weights. 2. Review of the care plan dated 10/18/17 related to diet and eating showed resident #147 was on a weight loss regimen. The interventions included weekly weights. Review of a physician order dated 4/11/17 showed an order for weekly weights. Review of the weight record showed the resident was weighed on the following dates: 8/5/17, 9/8/17, 9/20/17, 11/8/17, 11/9/17. 3. Interview on 11/16/17 at 2 PM with the DON revealed the expectation was for weights to be done on admission, and weekly for the first four weeks, then per orders. She confirmed it was the expectation care plans be followed.	F 282	The Registered Dietitian has been re-educated to ensure monitoring of increased frequency weights and to ensure the weights are obtained per recommendation and physician's order. **Monitoring** Weekly audits of 5 random residents on each unit, by Unit Manager/designee. will be completed regarding locating, obtaining and documenting resident weights accurately in the resident's health record. Audits will be reported to the QAPI Committee monthly for analysis and recommendations, until compliance has been met and sustained.	

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F 309 F 309 SS=D	Continued From page 19 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 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 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.	F 309 F 309	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Corrective Actions Residents #172 and #173 no longer reside in the facility. Corrective actions for these two residents could not be remediated. Others Potentially Affected Residents evaluated and deemed to benefit from a bowel management program are potentially affected. The DNS/designee audited residents on a bowel management program and IV Antibiotics to identify any other residents potentially affected. Systemic Changes The Admissions Team and Licensed Nurses will be educated on the process for admitting patients who are on IV antibiotics and will require first dosing within 12 hours. Education will be completed on or before 12/29/17, to include notification of the physician and pharmacy regarding alternative possibilities to ensure residents receive their required medications.	12/29/17

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F 309	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure necessary care and services were provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 of 2 sample residents (#173) with bowel management programs. Additionally, the facility failed to ensure physician orders were followed for 1 of 3 sample residents (#172) who received intravenous (IV) antibiotics. The findings were: 1. Review of the medical record showed resident #173 lost bowel function after spinal surgery, was admitted to the facility from the hospital on 9/3/17, and remained at the facility until 11/3/17. Review of the 9/3/17 admission orders showed instructions for staff to implement the following bowel management program daily at 5:30 AM: Give caffeine drink, administer a suppository, get up to the commode for 30 minutes, perform digital stimulation up to 3 times as needed, wait 10 -15 minutes, and perform digital stimulation again as needed. The following concerns were identified: a. Review of the 9/18/17 nursing notes showed the resident needed another bowel product, however, there was no evidence physicians or other nurses responded to this. Review of all subsequent nursing notes showed the bowel program was done, but effectiveness was not documented. b. Review of the bowel movement records showed the CNAs documented the bowel movements 10 of 19 days in October 2017. The DON was unable to find documentation of bowel movements for the other days in October 2017 and the month of September 2017.	F 309	**Monitoring** Weekly audit by Unit Manager/designee of new admissions who are ordered to receive IV antibiotics, and residents who require a bowel management program. Audit findings will be reported to the QAPI Committee monthly, for analysis and recommendations. Audits will continue until the QAPI Committee determines that compliance has been met and sustained.	

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F 309	Continued From page 21 c. Review of the physician visit note, dated 10/11/17, showed the bowel regime prior to coming to the facility was digital stimulation and complete rectal evacuation, however, at the facility "neither of these have occurred in a timely manner, nor have they been scheduled throughout the day." d. Interview on 11/15/17 at 3:50 PM with RN#1, RN#2, and RN#3 revealed they did not realize documentation regarding the effectiveness of the complex bowel program was not included in the record. All stated there should have been daily documentation regarding the effectiveness of the bowel program. 2. Review of the 10/7/17 hospital discharge orders showed resident #172 was being transferred to the nursing home with a discharge diagnosis of bacteremia. The orders included an antibiotic, Ancef (cefazolin) 2 gm IV every 8 hours until further orders, "next dose due at 9 PM tonight." Review of the October 2017 MAR showed the resident was admitted on 10/7/17 and there was an order for cefazolin in D5W solution 2 gm/100 ml to be administered at 6 AM, 2 PM, and 10 PM daily beginning on 10/7/17 at 10 PM. The following concerns were identified: a. Review of the MAR showed the 10 PM dose on 10/7/17 and the 6 AM dose on 10/8/17 were not administered. Further, the 10 PM dose on 10/10/17 was not administered. b. Review of the nursing notes failed to show any communication to the physician regarding the medication and the gap in the administration. c. Interview with the DON on 11/15/17 at 4:37 PM verified the medication was not administered on 10/7/17 due to it not being available through a local pharmacy. She stated the medication was received at 2 AM on 10/8/17. The DON was	F 309		

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F 309	Continued From page 22 unable to find an explanation as to why the 10/8 and 10/10 doses were missed. The DON stated the expectation was for the order to be followed or for the physician to be notified for clarification. d. According to Smith, Duell, and Martin in "Clinical Nursing Skills: Basic to Advanced Skills," 7th Edition, 2008: "Skill and functions that professional nurses perform in daily practice include: ... Administer treatments per physician's order."	F 309		
F 312 SS=E	ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.24(a)(2) (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 resident and staff interview, medical record review, and review of bathing documentation, the facility failed to ensure 15 of 23 sample residents (#2, #4, #40, #49, #52, #60, #95, #101, #105, #124, #145, #147, #158, #163, #172) and 4 non-sample residents (#3, #17, #68, #69) who required assistance with bathing/oral hygiene were provided assistance as required. The findings were: 1. Review of the 10/23/17 quarterly MDS assessment showed resident #49 required extensive assistance for bathing and personal hygiene. Review of the care plan with a review date of 11/3/17 showed the resident took showers and required "total assistance" with the task. There was no preference included as to the number of times per week. Review of the	F 312	ADL CARE PROVIDED FOR DEPENDENT RESIDENTS Corrective Actions Residents # 105 and #172 no longer reside at the facility. Residents # 17 & ~~#95~~ #4 receive oral care every shift as the resident allows. Residents #2, #4, #40, ~~#49~~, #52, #60, ~~#95~~, #101, #124, #145, #147, #158, #163, #3, #17, #68, and #69 have individualized care plans updated with bathing preferences and are being bathed per individual preferences. Resident #68 is offered a "shampoo shower cap" in between bathing when their hair becomes oily. Others Potentially Affected All residents have the potential to be affected by this practice.	12/29/17

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(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 312	Continued From page 23 bathing/shower documentation provided for August 2017 to November 2017 showed there were times when the resident went more than 10 days without a shower. There were no refusals noted. The dates of the showers greater than 10 days apart were as follows: a. 8/27/17 to 9/9/17 b. 9/9/17 to 9/20/17 c. 10/13/17 to 10/26/17 2. Review of the 9/20/17 quarterly MDS assessment showed resident #101 required extensive assistance with bathing. Review of the care plan showed it was last reviewed on 9/27/17, the resident preferred a shower in the mornings, and required assistance with parts of the process. Additionally, the care plan showed the resident required set-up and supervision help for oral hygiene tasks. Review of the bathing/shower documentation provided for August 2017 to November 2017 showed there were times when the resident went more than 10 days without a shower. There were no refusals noted. The dates of the showers greater than 10 days apart were as follows: a. 8/28/17 to 9/24/17 b. 10/8/17 to 10/21/17 3. Review of the 11/1/17 to 11/14/17 oral care documentation showed the resident received "oral cares" 3 times. 4. Review of the 10/19/17 quarterly MDS assessment showed resident #124 required extensive assistance with personal hygiene and bathing. Review of the care plan, last reviewed on 11/3/17, showed the resident preferred a bath in the mornings two times per week and required extensive assistance to complete the task.	F 312	**Systemic Changes** Nursing staff will be educated on obtaining resident bathing preferences and providing resident care to ADL dependent residents, on or before 12/29/17. **Monitoring** Weekly audits on each unit by the Unit Manager/designee regarding resident bathing preferences and resident care for ADL dependent residents. Audit findings will be reported to the QAPI Committee monthly, for analysis and recommendations until the committee determines compliance has been met and sustained.	

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	535042	A. BUILDING _____ B. WING _____	C 11/16/2017

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F 312	Continued From page 24 Interview with the resident on 11/14/17 at 10:14 AM revealed a concern that s/he had not had a bath in 2 weeks. Review of the bathing/shower documentation provided for August 2017 to November 2017 showed there were times when the resident went more than 7 days without a bath or shower. There were no refusals noted. The dates of the showers greater than 7 days apart were as follows: a. 8/23/17 to 9/2/17 b. 11/1/17 to 11/14/17 5. Review of the 8/31/17 quarterly MDS assessment showed resident #3 required extensive assistance with bathing and was cognitively intact with a BIMS score of 15. Interview with the resident on 11/14/17 at 5:21 PM revealed the resident made an appointment with a CNA to have a bath or shower at 5 PM. The resident was upset because the staff member did not show up, and there was no one available to help him/her. The resident stated there was not enough help to get a bath or shower more than once per week and sometimes it was longer. S/he stated it made him/her feel "deflated" and "scared to go around other people" because of "not being clean." Review of the bathing/shower documentation provided for October and November 2017 showed there were no refusals noted, the resident was bathed on 10/11/17, 10/20/17, 10/26/17, 10/30/17 and 11/16/17. 6. Review of the medical record showed resident #172 was admitted on 10/7/17 for skilled services. Review of the 10/14/17 admission MDS assessment showed the resident required extensive assistance for bathing. Review of a grievance form dated 10/9/17 showed the family	F 312		

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F 312	Continued From page 25 was concerned about the resident not having a shower. Review of the bathing documentation showed the resident received a shower on 10/11/17 and not again during his/her stay with a discharge date of 10/18/17. There were no documented refusals. 7. Review of the 8/21/17 quarterly MDS assessment for resident #60 showed bathing activity had not occurred during the seven day look back period. Review of the previous annual MDS assessment with an assessment reference date (ARD) of 2/20/17 showed resident required total assist with 2+ person's physical assist for bathing. Review of the care plan, last reviewed on 8/24/17, showed the resident preferred a shower and was not able to care for bathing tasks on his/her own. There was no preference included as to the number of times per week. Review of the bathing/shower documentation provided showed for August 2017 to November 2017 there were times when the resident went more than 10 days without a shower. The dates of the showers greater than 10 days apart were as follows: a. No shower in August until 8/14/17 b. 8/28/17 to 9/9/17 c. 9/9/17 to 9/21/17 d. 9/21/17 to 10/4/17 8. Review of the 9/18/17 quarterly MDS assessment for resident #4 showed bathing activity had not occurred during the seven day look back period. Review of the previous admission MDS assessment with an ARD of 6/21/17 showed the resident required 1 person limited assist for bathing. Review of the care plan, last reviewed on 9/22/17, showed no preference for showers or baths or the number of times per	F 312		

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F 312	Continued From page 26 week. Review of the bathing/shower documentation provided showed for August 2017 to November 2017 there were times when the resident went more than 10 days without a shower. The dates of the showers greater than 10 days apart were as follows: a. No shower in August until 8/13/17 b. 8/13/17 to 8/27/17 c. 9/5/17 to 9/19/17 d. 9/23/17 to 10/4/17 9. Review of the 8/21/17 quarterly MDS assessment for resident #163 showed that bathing activity had not occurred during the seven day look back period. Review of the care plan, last reviewed on 8/24/17, showed the resident preferred a shower and required total assistance with bath. Review of the bathing/shower documentation provided showed for August 2017 to November 2017 there were times when the resident went more than 10 days without a shower. The dates of the showers greater than 10 days apart were as follows: a. No shower in August until 8/13/17 b. 9/6/17 to 9/19/17 c. 9/26/17 to 10/15/17 10. Interview on 11/16/17 at 12:40 PM with resident #69 revealed s/he wanted a shower twice a week and only received one a week. Review of the 10/26/2017 quarterly MDS assessment showed the resident required physical help in part of bathing activity. Review of the 11/3/17 care plan goal related to hygiene/ADLs showed the resident took showers, and wanted to be clean, neat and well groomed daily. There was no preference included as to the number of times per week. Review of the bathing/showering records for October and	F 312		

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F 312	Continued From page 27 November 2017 showed the resident went 8 days without a shower from 10/30/17 to 11/7/17. 11. Interview on 11/13/17 at 3:00 PM with resident #147 revealed s/he went two weeks without a shower, and on other days s/he gave him/herself a sponge bath in the bathroom. Review of the 10/9/17 quarterly MDS assessment showed the resident required extensive assistance for bathing and hygiene. Review of the 10/18/17 care plan goal showed the resident required cuing to perform this activity, and the resident preferred to be clean and odor free daily. There was no preference included as to the number of times per week. Review of the bathing/shower documentation showed there were times when the resident went more than 10 days without a shower. The dates of the showers greater than 10 days apart were as follows: a. 8/23/17 to 9/9/17 b. 9/9/17 to 9/20/17 c. 10/14/17 to 10/29/17 d. 10/29/17 to 11/19/17 12. Review of the 10/26/17 annual MDS assessment showed resident #68 did not have cognitive impairment and had functional limitation in range of motion in both legs. Review of the care plan, revised on 11/8/17, showed the resident required extensive assistance with personal hygiene and bathing due to muscle weakness. During an interview on 11/13/17 at 3:30 PM, the resident stated sometimes s/he did not receive a shower and shampoo for 7 to 10 days and this caused his/her hair to become oily. The resident further stated, "It feels awful to have to be around other people when my hair is so oily." Review of the bathing/shower records showed the resident did not receive a	F 312		

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F 312	Continued From page 28 bath/shower from 10/12/17 to 10/19/17 (7 days), 10/24/17 to 10/31/17 (7 days), and 11/7/17 to 11/14/17 (7 days). Further review showed no documented refusals during the prolonged periods without receiving bath/showers. 13. Review of the 11/2/17 quarterly MDS assessment showed resident #40 had moderate cognitive impairment and required extensive assistance with personal hygiene and bathing. Review of the care plan, revised on 11/8/17, showed the resident was unable to complete grooming tasks without assistance. Review of the bathing/shower records showed the resident did not receive a bath/shower from 8/14/17 to 8/26/17 (12 days), 8/26/17 to 9/3/17 (8 days), 9/9/17 to 9/22/17 (13 days), 9/29/17 to 10/14/17 (15 days), 10/16/17 to 10/23/17 (7 days), 10/23/17 to 10/30/17 (7 days), and 10/30/17 to 11/13/17 (14 days). Further review showed no documented refusals during the prolonged periods without receiving bath/showers. 14. Review of the 11/8/17 care plan showed resident #145 had moderate cognitive impairment and required extensive assistance with bathing and personal hygiene care due to limited mobility. Interview on 11/14/17 at 9:45 AM with the resident revealed s/he was had not received a shower 2 times a week per preference due to lack of staff. The resident further stated the CNAs worked very hard, but could only do so much when they are short-staffed. Review of the bathing/shower records showed the resident did not receive a bath/shower from 9/5/17 to 9/19/17 (14 days), from 9/27/17 to 10/4/17 (7 days), from 10/4/17 to 10/12/17 (8 days), 10/12/17 to 10/26/17 (14 days), 10/26/17 to 11/7/17 (12 days), and 11/7/17 to 11/14/17 (7 days). Further	F 312		

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F 312	Continued From page 29 review showed no documented refusals during the prolonged periods without receiving bath/showers. 15. Review of the 11/9/17 annual MDS assessment showed resident #52 had severe cognitive impairment and was totally dependent on staff for all personal hygiene care and bathing due to dementia and limited mobility. Review of the bathing/shower records showed the resident did not receive a bath/shower from 8/2/17 to 8/13/17 (11 days), 8/13/17 to 8/26/17 (13 days), 8/26/17 to 9/10/17 (15 days), 9/10/17 to 9/23/17 (13 days), 9/23/17 to 9/30/17 (7 days), 9/30/17 to 10/14/17 (14 days), and 10/14/17 to 10/25/17 (13 days). Further review showed no documented refusals during the prolonged periods without receiving bath/showers. 16. Review of care plan for resident #2 revealed s/he required total assistance of 2 staff for showers. Review of bathing records showed the resident was admitted on 8/14/17, received a shower or bath on 8/15/17, then was not bathed for seven days, and was discharged on 8/23/17. The record further showed the resident returned to the facility on 9/8/17. Documentation showed she refused a shower on 9/11/17 and was discharged on 9/15/17. The facility was not able to provide evidence the resident was offered a shower on the other six days of the 9/8/17-9/15/17 stay. The resident returned 10/14/17, was showered on 10/15/17 and 10/19/17, then was not showered or bathed for thirteen days. S/he was showered on 11/2/17, and was given one shower during the week of 11/5/17-11/11/17. 17. Review of the admission MDS assessment,	F 312		

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F 312	Continued From page 30 signed 10/17/17, for resident #105 revealed s/he required extensive assistance for transferring, dressing, toilet use and personal hygiene. Bathing was marked as "did not occur." Review of bathing records revealed the resident refused a bath or shower on 10/11/17. The facility was not able to provide evidence the resident was offered a shower on the other six days during the week of 10/8/17-10/14/17. The record further showed the resident was given a bath or shower once a week for the weeks of 10/15/17, 10/22/17, 10/29/17 and 11/5/17. The longest period between bathing was twelve days. 18. Review of the 7/3/17 quarterly MDS assessment showed resident #158 required extensive assistance with personal hygiene. Review of the 10/18/17 care plan showed the resident required staff of 1 to allow adequate time to complete bathing tasks before offering assistance. Review of the bathing shower documentation showed the resident went greater than 10 days without a shower during the following periods: 8/7/17 to 8/24/17 and 9/7/17 to 9/20/17. 19. Interview with the DON on 11/14/17 at 3:47 PM verified there were staff shortages of CNAs and licensed nurses. She was aware bathing services were not being provided as planned due to these staff shortages. 20. Review of the 9/28/17 quarterly MDS assessment showed resident #95 required extensive assistance with personal hygiene tasks. Review of the 11/1/17 to 11/16/17 oral care documentation showed the resident received "oral cares" 4 times.	F 312		

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F 312	Continued From page 31 21. Review of the 9/25/17 annual MDS assessment showed resident #17 required extensive assistance with personal hygiene. Review of the 10/17/17 care plan showed "staff of 1 obtain/set up oral hygiene supplies...every morning and night, including denture cup and solution for soaking dentures..." Review of the oral cares documentation for November 1-15, 2017 showed the resident went the following days with oral care performed only once: 11/1/17, 11/2/17, 11/6/17, 11/7/17 11/9/17, 11/10/17, 11/13/17. Oral care was not performed on 11/3/17, 11/11/17, or 11/15/17. 22. Interview with CNA #4 on 11/16/17 at 9:25 AM revealed oral cares were to be provided "at least in the mornings." The aide then stated "honestly it's not being done as often as it should due to lack of time." She stated "Some residents don't have supplies in their rooms then we have to go to the supply closet and see what can be found."	F 312		
F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 314	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Corrective Actions Resident #145 no longer resides at the facility. The facility cannot remediate monitoring of the open area, since the identification was prior to annual survey. Others Potentially Affected Residents with known pressure injuries have the potential to be affected by this practice.	12/29/17

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F 314	Continued From page 32 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff interview and review of policies and procedures, the facility failed to ensure monitoring and assessments were completed for 1 of 6 sample residents (#145) with pressure ulcers. The findings were: 1. Review of the 11/3/17 Braden risk assessment showed resident #145 was at risk for developing pressure ulcers due to limited mobility and chronic vascular ulcers on both legs and feet. Review of the 10/30/17 quarterly MDS assessment showed the resident had vascular ulcers, but did not have pressure ulcers. Review of the November 2017 nursing notes showed a pressure ulcer on the right buttock was first identified on 11/5/17 and was described as 3.5 by 0.7 centimeter open area caused by sitting on catheter tubing. Further review of the nursing notes and additional reviews of wound monitoring documentation revealed staff did not document anything about the pressure ulcer after it was initially identified on 11/5/17. On 11/14/17 at 11:20 AM, CNA #1 was observed assisting the resident to the recliner chair in his/her room and an open, moist, stage II pressure ulcer was observed on the resident's right buttock. Further observation revealed the pressure ulcer was approximately the size of a nickel. At that time the CNA stated she had not been aware of the pressure ulcer before 11/14/17. Review of the care plan, revised on 8/10/17, showed no interventions for the care and treatment of the newly-developed pressure	F 314	The Treatment Nurse evaluated all other residents with pressure injuries in the facility. No other residents identified without assessments and monitoring. **Systemic Changes** Nursing staff will be re-educated regarding weekly completion of skin assessments and the facility policy and procedure for pressure injury management, including proper identification and documentation of pressure and no pressure injuries. **Monitoring** Weekly audit by the Wound Nurse/designee, on each unit for residents who have pressure injuries; to determine compliance of licensed nurse monitoring, wound documentation, updating plan of care for necessary wound concerns, and communicating care needs to direct care staff. Audit findings will be reported to the QAPI Committee monthly, for analysis and recommendations, until the committee determines that compliance has been met and sustained.	

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F 314	Continued From page 33 ulcer. Interview on 11/16/17 at 9 AM with RN #4 revealed she was unable to find documentation that showed the pressure ulcer was being monitored. She further stated the expectation was that weekly assessments be completed and documented for pressure ulcers. Interview on 11/16/17 at 10 AM with LPN #1, who was responsible for the care and monitoring of wounds, revealed she was not aware of the pressure ulcer. 2. Review of the policy and procedure titled, "Pressure Ulcer Risk Assessment", revised April 2016, showed the general guidelines included: Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptom of irritation or breakdown. Immediately report any signs of developing pressure ulcer to the supervisor.	F 314		
F 318 SS=E	INCREASE/PREVENT DECREASE IN RANGE OF MOTION CFR(s): 483.25(c)(2)(3) (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 318	INCREASE/PREVENT/DECREASE IN RANGE OF MOTION Corrective Actions Residents # 60, #40, #163, and #69 were assessed by the Director of Rehab and not found to have had any decline in function or ROM. Residents #60, #40, #163, and #69 are receiving Restorative Services per plan of care. Others Potentially Affected Residents receiving restorative services have the potential to be affected by this practice.	12/29/17

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F 318	Continued From page 34 Based on medical record review and staff and resident interview, the facility failed to consistently provide restorative nursing care for 3 of 7 sample residents (#40, #60, #163) and 1 non-sample resident (#69) who required this care to maintain range of motion. The findings were: 1. Review of the restorative nursing notes showed staff developed a restorative program for maintaining range of motion for resident #60. The program was to be provided 3 times a week. Further review showed restorative nursing was not provided 3 times a week in September 2017, October 2017, and November 2017. Interview with the resident on 11/16/17 at 12:15 PM revealed range of motion therapy was important to him/her due to muscle weakness. At that time the resident stated the range of motion therapy was not provided as scheduled because there was not enough staff. 2. Review of the 7/20/17 physician's orders for resident #40 showed the physician ordered restorative nursing for maintaining range of motion to be provided 2 - 3 times a week. Review of the restorative nursing records showed it was not provided as ordered during 1 or more weeks in August 2017, September 2017, and October 2017. 3. Review of the 10/25/17 physician's orders for resident #163 showed the physician ordered restorative nursing for maintaining range of motion to be provided 2 - 3 times a week. Review of the restorative nursing records showed it was provided only 1 time in October 2017 and one time in November 2017. 4. Review of the restorative nursing notes	F 318	**Systemic Changes** New CNA's are being hired and trained to meet the needs of the facility, until all open positions are filled. Nursing Administration education will be completed on or before 12/29/17, specifying the criteria for pulling RNA's to the floor for direct care. **Monitoring** Weekly audit by SDC/designee on each resident's RNA programs being completed per plan of care. Audit findings will be reported to the QAPI Committee monthly, for analysis and recommendations, until the committee has determined that compliance has been met and sustained.	

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F 318	Continued From page 35 showed staff developed a restorative program for maintaining range of motion for resident #69 and determined staff needed to provide this care 2 to 3 times a week. Further review showed restorative nursing was not provided during 1 week in October 2017, and was provided only 3 times in November 2017. 5. Interview on 11/16/17 at 11:10 AM with the RN responsible for the oversight of the restorative program, RN #3, revealed the residents had not received the scheduled restorative care because the restorative staff were reassigned resident care tasks when the facility was short-staffed.	F 318		
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 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	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Corrective Actions Resident #118's bowel protocol medications have been updated to reflect the resident's current needs. Others Potentially Affected Residents requiring bowel protocol medications have the potential be affected by this practice. Systemic Changes Licensed Nurses will be educated on bowel protocol, documenting bowel medication efficacy, and monitoring progress in bowel regularity. Education will be completed on or before 12/29/17 by the DON/designee.	12/29/17

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F 329	Continued From page 36 483.45(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 and staff interview, the facility failed to ensure the medication regimens were free of unnecessary medications for 1 of 25 sample residents (#118). The findings were: 1. Review of the medical record for resident #118 showed diagnoses which included diabetes, paraplegia, anxiety, depression, and muscle weakness. Review of the care plan showed the resident required assistance with toileting, with interventions including: "I need total assistance of 2 staff with toileting. I use a brief as I have no sensation, and do not know till after I have gone." Review of the medication administration record (MAR) revealed the resident had an order with a start date of 7/7/17 for bisacodyl suppository 10 milligrams (mg) "Insert 1 suppository rectally at bedtime for Health maintenance. Hold only for diarrhea" and an order with a start date of 7/8/17	F 329	Monitoring Weekly audits by DON/designee for each unit on bowel protocol compliance. Audit findings will be reported to the QAPI Committee monthly for analysis and recommendations, until the committee determines that compliance has been met and sustained.	

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F 329	Continued From page 37 for Colace capsule, 100 (mg), "Give 1 capsule by mouth one time a day for health maintenance." Further, the resident had an order with a start date of 10/3/17 for Imodium A-D "Give 1 tablet by mouth as needed for Diarrhea (Give 2 tabs for initial encounter and 1 tab for each episode after NTE [not to exceed] 4 tabs/day)". The following concerns were identified: a. Review of the September MAR showed the Bisocodyl was refused by the resident 24 times, was held by the nurse 4 times, and was given twice. b. The October MAR showed the Bisocodyl was refused by the resident 21 times, was held by the nurse 7 times, was given twice, and one day was not documented. The Imodium A-D, ordered 10/3/17, was given on 9 different days, with two doses on 2 of those days. c. The November MAR (1st-15th) showed the Bisocodyl was refused by the resident 12 times, was held by the nurse 2 times, and was given once. The Imodium A-D was given on 4 different days. d. Interview on 1/16/17 at 2 PM with the DON revealed she was unaware of the resident's episodes of diarrhea and confirmed the resident would need "some kind of bowel protocol to provide some stability."	F 329		
F 334 SS=E	INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS CFR(s): 483.80(d)(1)(2) (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization,	F 334		

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F 334	Continued From page 38 each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is	F 334	INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS Corrective Actions Resident #105 no longer resides at the facility. Res #2, #21, and #118 have been offered pneumonia vaccines. Others Potentially Affected All residents have the potential to be affected by this practice. Systemic Changes The Interdisciplinary Discipline Team will develop a new admissions process that will include the necessary information on pneumonia vaccine status. Licensed Nurses will be educated by the Infection Prevention Nurse/designee on the process for obtaining pneumonia vaccine consent and offering pneumonia vaccines. Education will be completed on or before 12/29/17. Monitoring Weekly audits on each unit by the IPN/designee on obtaining consent for and offering pneumonia vaccines to residents. Audit findings will be reported to the QAPI Committee monthly, for analysis and recommendations, until the committee determines compliance has been met and sustained.	12/29/17

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F 334	Continued From page 39 medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review and facility policy review, the facility failed to ensure residents were screened for the pneumococcal vaccine or were offered the pneumococcal vaccine for 4 of 5 sample residents (#2, #21, #105, #118) reviewed for the information. The findings were: 1. Review of the admission MDS assessment for resident #2, signed 8/27/16, showed section O-0300 A "Is the resident's Pneumococcal vaccination up to date?" was marked "not assessed." 2. Review of the admission MDS assessment for resident #21, signed 9/8/17, showed the section to determine pneumococcal vaccination status (O-0300 A) was marked "not assessed."	F 334		

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F 334	Continued From page 40 3. Review of the admission MDS assessment for resident #105, signed 10/17/17, showed section O-0300 A was marked "not assessed." 4. Review of the admission MDS assessment for resident #118, signed 7/18/17, and quarterly MDS assessment signed 10/19/17, showed section O-0300 A was marked "not assessed." 5. Interview on 11/16/17 at 1:03 PM with RN#3 revealed when there was no information in the resident's record regarding previous receipt of the pneumococcal vaccine, they marked the MDS section O-0300 A as "not assessed." She further stated they didn't usually "have privy" to that information, and didn't attempt to gather the information from other sources, such as the resident's family, primary doctor or care provider. 6. Interview on 11/16/17 at 2 PM with the DON confirmed the facility was unable to provide documentation which showed residents #2, #21, #105 and #118 were screened for the pneumococcal vaccine upon admission or that education was provided to the residents or families. Further, the DON provided an immunization report with a date range of 10/1/16 to 11/30/17 which showed these residents had not received a pneumococcal vaccine while at the facility. 7. Review of the policy "Pneumococcal Vaccination - Resident/Patient" showed the following procedure: a. Newly admitted residents will be offered the pneumococcal vaccine (See ACIP guidelines for complete details) b. Each resident's immunization status will be	F 334		

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F 334	Continued From page 41 determined prior to vaccination, and will be documented in their individual medical record. c. Signed, informed consent in the form of a discussion/education regarding risks and benefits will occur prior to vaccination. (This may be with their authorized representative when appropriate.) CDC Vaccination Information Sheet (VIS) will be reviewed with resident/representative also. d. Residents may refuse vaccination. Vaccination refusal and reasons why (e.g., allergic, contraindicated, did not want vaccine, etc.) should be documented by the facility on the consent/declination form. e. Vaccine administered at time of admission will be given according to the Standing Order: Pneumococcal vaccine upon admission to the facility unless it has already been received/or is medically contraindicated. f. Re-vaccinations will be administered according to primary physician's order....	F 334		
F 353 SS=E	SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS CFR(s): 483.35(a)(1)-(4) 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	F 353		

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F 353	Continued From page 42 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. (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 medical record review, staff interview, resident interview, review of bathing documentation, and review of restorative nursing program documentation, the facility failed to ensure there were adequate numbers of staff to provide care in a dignified and timely manner.	F 353	SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS Corrective Actions The facility is actively recruiting eligible CNA and Licensed Nurse candidates to fill open staff positions. Residents #105 and #172 no longer reside in the facility. Residents #2, #3, #4, #40, #49, #52, #60, #68, #69, #101, #124, #145, #147, #158, and #163 are receiving timely bathing. Residents #17, #95, and #101 are receiving oral care as required. Resident #40, #60, #69, and #163 are receiving RNA services per care plan. Others Potentially Affected All residents have the potential to be affected by this practice. Systemic Changes The facility continues to actively recruit, hire, and train eligible candidates for CNA and Licensed Nurse positions. Nursing Staff education will be completed on or before 12/29/17, related to resident bathing, oral care, and restorative services. The Nursing Administration Team and the Scheduler will be educated on staffing patterns and providing essential resident care.	12/29/17

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F 353	Continued From page 43 The census was 170. The findings were: 1. Interview with the DON on 11/14/17 at 3:47 PM verified there were staff shortages of CNAs and licensed nurses. The DON provided data that showed as of 10/31/17 there were 8 full-time and 1 part-time positions for CNAs that were vacant and 8 full-time nurse positions which were vacant. She also stated there were currently 7 CNAs who were on light work duty and 1 bath aide who was out on a medical leave. The DON stated they were actively hiring and had bonus incentives in place. She was aware the length of time to have call lights answered was extended, and bathing and restorative services were not being provided as planned due to these staff shortages. 2. Review of the bathing documentation from August 2017 to November 15, 2017 showed the following residents were identified as not receiving baths timely with lapses greater than 7 days between baths/showers: #2, #3, #4, #40, #49, #52, #60, #68, #69, #101, #105, #124, #145, #147, #158, #163, and #172. For details see F312. 3. Review of the November 2017 ADL documentation related to oral care showed the following residents were identified as not having care provided as required: #17, #95, #101. For details see F312. 4. Review of the restorative nursing program documentation for September, October and November 2017 showed times when residents #40, #60, #69 #163 who required this care, were not provided the services as planned. See F318 for details.	F 353	Monitoring Weekly audit of open staffing positions for CNA's and Licensed Nurses will be completed by the DON/HR Director to determine direct care staffing needs/recruitment. Audit findings will be reported to the QAPI Committee for analysis and recommendations, until the committee determines that compliance has been met and met and sustained.	

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F 353	Continued From page 44 5. Interview with 12 residents during the group meeting on 11/14/17 revealed the lack of staff caused the following concerns for the residents: a. Response to call lights took 45 minutes to an hour. b. It made the residents feel guilty when they requested assisted because they knew the CNAs were doing the best that they could with the limited number of staff. c. Staff attitude was affected by being overworked and their behavior was abrupt. d. Sometimes the residents went 9 to 14 days without showers. e. Restorative nursing was not provided as scheduled. f. Medications were administered late because the nurses had to help the CNAs. g. Verbalizing these concerns to the administrator was "like talking to the wind." 6. Interview with CNA #4 on 11/16/17 at 9:25 AM revealed oral cares were to be provided "at least in the mornings." The aide then stated "honestly it's not being done as often as it should due to lack of time." She stated "Some residents don't have supplies in their rooms then we have to go to the supply closet and see what can be found."	F 353		
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or 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.	F 371	FOOD PROCURE,STORE/PREPARE/SERVE – SANITARY Corrective Actions The facility kitchens (Main, East Unit, and West Unit) will be deep cleaned by 12/29/17. The ice machines (main kitchen and RRU kitchen) will be deep cleaned by 12/29/17.	12/29/17

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F 371	Continued From page 45 (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 sanitation requirements were met in 3 of 5 kitchens (the main kitchen, East unit kitchen, West Unit Kitchen). In addition, 2 of 3 ice machines (main kitchen and rapid recovery unit) were found to be in need of cleaning and sanitation. The findings were: 1. Observation in the West unit kitchen showed a tray of 24 thawed health shakes. There were no dates marked on the containers or the tray to show when they expired. The information on the carton showed "use within 14 days after thawing." 2. Observation of the meal service in the East unit kitchen on 11/15/17 at 11:28 AM showed there was no sanitizer solution prepared to hold the wet wiping cloths. Two wet cloths were located on the sink/counter. In addition, in this kitchen there was damage to the wooden shelving/cabinets being	F 371	Thawed health shakes have visibly labeled expiration dates. The East Unit kitchen has prepared sanitizing solution to hold wet wiping clothes, and wet clothes will be kept in the sanitizing solution instead of other surfaces. The East Unit kitchen damaged wooden shelving and cabinets will be repaired or replaced by 12/29/17; to provide cleanable surfaces. The East Unit kitchen north wall will be painted before 12/29/17. The labeling/date marking of food items will be consistent and accurate for opened, expired, and use by dates; by 12/29/17. <u>Others Potentially Affected</u> All residents have the potential to be affected by this practice. <u>Systemic Changes</u> Dietary staff education, on or before 12/29/17, related to cleaning schedules, labeling and dating thawed health shakes, sanitizing solution preparation and use, cleanable surfaces, ice machine cleaning, and identifiable labeling and dating of foods for opened, expiration, and use by dates.	

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F 371	Continued From page 46 used to store clean equipment. The wood was crumbling and was in an un-cleanable condition. The north wall in this kitchen was also in need of painting. The paint on the wall was extensively marred and peeling. 3. Observation on 11/13/17 at 3:12 PM and on 11/15/17 at 11:06 AM showed the date-marking of items in the walk-in refrigerator was unclear. There were some items marked with a date on a piece of masking tape and there was nothing to show what the date meant. There were other items including egg salad and tuna salad that had a label with typed information and blanks that could be filled in. These two items had only the "use by" date filled in and it showed 11/10 on the egg salad and 11/12 on the tuna salad. 4. Observation on 11/13/17 at 3:12 PM showed the main kitchen ice machine had a rust-colored build-up under the hinges of the door. 5. Observation on 11/15/17 at 11:55 AM in the rapid recovery unit showed the ice machine had a pink discoloration on the interior components where the ice was located. 6. Interview with the Certified Dietary Manager (CDM) on 11/15/17 at 2:20 PM revealed the dates were in the wrong place on the labels, and they were actually the dates the items were prepared. She confirmed the system was unclear and there needed to be a clear expiration date marked. The CDM further verified the ice machines were in need of service and cleaning, the health shakes were expected to be date-marked with expiration, and the sanitizing solution should have been available during the meal service.	F 371	Monitoring Weekly audits by the Dietary Manager for: • Labeling/dating thawed health shakes • Proper use of sanitizing solution for cleaning and storage of wet wiping cloths • Kitchen cleaning tasks completed • Cleanable surfaces • Ice machine cleaning. Audit findings will be reported to the QAPI Committee for analysis and recommendations, until the committee determines that compliance has been met and sustained.	

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	535042	A. BUILDING _____ B. WING _____	C 11/16/2017

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F 371	Continued From page 47 7. According to Food Code 2013, U.S. Public Health Service 4-101.11: "Materials that are used in the construction of UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT may not allow the migration of deleterious substances or impart colors, odors, or tastes to FOOD and under normal use conditions shall be ...(E) Resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition." 8. According to Food Code 2013, U.S. Public Health Service: 3-501.17 "(A)...refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days." 9. According to Food code 2013, 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." 10. According to Food Code 2013, U.S. Public Health Service: 3-304.14 " ...(B) Cloths in-use for wiping counters and other EQUIPMENT surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under § 4-501.114; "	F 371		

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F 425 SS=D	PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH CFR(s): 483.45(a)(b)(1) (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who– (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure medication was available to be administered as ordered for 1 of 3 sample residents (#172) with IV antibiotics. The findings were: Review of the 10/7/17 hospital discharge orders showed resident #172 was being transferred to the nursing home with a discharge diagnosis of bacteremia. The orders included an antibiotic, Ancef (cefazolin) 2 gm IV every 8 hours until further orders, "next dose due at 9 PM tonight." Review of the October 2017 MAR showed the resident was admitted on 10/7/17 and there was an order for cefazolin in D5W solution 2 gm/100 ml to be administered at 6 AM, 2 PM, and 10 PM daily beginning on 10/7/17 at 10 PM. The following concerns were identified: a. Review of the MAR showed the 10 PM dose on 10/7/17 and the 6 AM dose on 10/8/17 were not administered. Further, the 10 PM dose on 10/10/17 was not administered.	F 425	PHARMACEUTICAL SVC – ACCURATE PROCEDURES, RPH Corrective Actions Resident #172 no longer resides at the facility. Corrective action could not be remediated for this resident. Others Potentially Affected Residents with new IV Antibiotic orders have the potential to be affected by this practice. Systemic Changes The Admissions Team and Licensed Nurses will be educated on the process when admitting patients who have IV Antibiotics that will require first dosing within the first 12 hours. Education will be completed on or before 12/29/17. Monitoring by Unit Managers Weekly auditing of new IV Antibiotic orders, for timely receipt and administration of medication. Audit findings will be reported to the QAPI Committee for analysis and recommendations, until the committee determines that compliance has been met and sustained.	12/29/17

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F 425	Continued From page 49 b. Interview with the DON on 11/15/17 at 4:37 PM verified the medication was not administered on 10/7/17 due to it not being available through the local back-up pharmacy. She stated the medication was received at 2 AM on 10/8/17. The DON was unable to find an explanation as to why the 10/8/17 and 10/10/17 doses were missed.	F 425		
F 428 SS=E	DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON CFR(s): 483.45(c)(1)(3)-(5) c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a	F 428	DRUG REGIMEN REVIEW, REPORT, IRREGULAR, ACT ON Corrective Actions Residents #40, #60, #64, #101, #145, #147, #158, and #159 have had pharmacy recommendations reviewed and addressed by physician. Others Potentially Affected All residents have the potential to be affected by this practice. Systemic Changes Unit Manager education by DON/designee on or before 12/29/17 regarding the requirements of addressing pharmacy recommendations; including obtaining required documentation from Physician's on rationale for not following Pharmacist's recommendations. The Consultant Pharmacist will change the format of recommendations to assist the physician in meeting regulatory requirements.	12/29/17

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F 428	Continued From page 50 separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, drug regimen review, and staff interview, the facility failed to ensure pharmacist recommendations were addressed for 8 of 25 sample residents (#40, #60, #64, #101, #145, #147, #158, #159). The findings were: 1. Medical record review showed resident #147 was admitted on 4/28/17 with diagnoses that included post traumatic stress disorder. Review of the October 2017 MAR showed orders for citalopram 50 mg (antidepressant) and Trazadone 50 mg (antidepressant/sedative). Review of the nursing care plan, last reviewed 10/18/17, showed "staff to consult with physician to promote lowest effective dosage, and to	F 428	**Monitoring** Weekly audit for each unit by the Unit Manager, on return/acknowledgement of Pharmacist recommendations from the physician. Audit findings will be reported to the QAPI Committee monthly for analysis and recommendations, until the committee determines that compliance has been met and sustained.	

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F 428	Continued From page 51 implement dose reduction/medication elimination when warranted." Review of the 10/4/17 Pharmacist Medication Regimen Review (MRR) showed a gradual dose reduction (GDR) was recommended for these medications. Review of the medical record showed the recommendation had not been addressed by the physician. 2. Medical record review showed resident #158 was admitted on 4/10/15 with diagnoses that included anxiety and depression. Review of the October 2017 MAR showed orders for bupropion 150 mg (antianxiety), methylphenidate 30 mg (stimulant), and diazepam 5 mg (antianxiety). Review of the nursing care plan, last reviewed 10/18/17, showed "staff to consult with physician to promote lowest effective dosages are utilized and implement dose reduction/medication eliminated when warranted." Review of the 6/7/17, 8/2/17, 9/5/17, and 10/4/17 Pharmacist MRRs showed repeated recommendations for GDRs. Review of the medical record showed the recommendations had not been addressed. 3. Medical record review showed resident #60 had diagnoses that included depression and anxiety. Review of the Pharmacist MRRs showed repeated recommendations on 5/2/17, 8/1/17, and 9/4/17 for GDRs related the residents psychoactive medications: Lexapro (antidepressant), Wellbutrin (antidepressant), and clonazepam (antidepressant/sedative). Review of the medical record showed the recommendations had not been addressed. 4. Review of the Pharmacist MRR, dated 10/10/17, for resident #101 showed the pharmacist recommended discontinuing the use of omeprazole (medication for heartburn)	F 428		

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F 428	Continued From page 52 because it was 1 of 2 medications prescribed for the same diagnosis. Review of the medical record showed no documented response to the recommendation and no changes in the medication regime. 5. Review of the Pharmacist MRR, dated 10/17/17, for resident #64 showed the pharmacist noted the potential effect the resident's medications could have on kidney function and the pharmacist recommended lab testing to evaluate kidney function. Review of the medical record showed no documented response to this recommendation. 6. Review of the August 2017 to October 2017 behavior monitoring records for resident #40 showed staff were monitoring the resident's depression and the effectiveness of daily doses of citalopram (antidepressant). Review of the Pharmacist MRR, dated 10/10/17, showed the pharmacist noted a gradual dose reduction was due for the citalopram. Review of the medical record showed no documented response to the recommendation and no changes in the medication regime. 7. Review of the August 2017 to October 2017 behavior monitoring records for resident #145 showed staff were monitoring the effectiveness of an antipsychotic medication called aripiprazole for resident #145. Review of the Pharmacist MRR, dated 10/3/17, showed the pharmacist noted the medication may cause involuntary movement including tardive dyskinesia, but an assessment for this had not been completed in the past 6 months. Review of the medical record confirmed the assessment was lacking and daily medication dose remained unchanged.	F 428		

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F 428	Continued From page 53 8. Review of the August 2017 to October 2017 behavior monitoring records for resident #159 showed staff were monitoring the resident's depression and the effectiveness of daily doses of citalopram (antidepressant). Review of the Pharmacist MRR, dated 10/10/17, showed the pharmacist recommended decreasing the citalopram to 20 milligrams or changing to an alternative therapy, such as escitalopram, if antidepressant therapy is needed. Review of the medical record showed no documented response to the pharmacist's recommendation. 9. Interview on 11/16/17 at 11:40 AM with the DON revealed the pharmacy recommendations were discussed at care conferences. However the GDRs were not always being done and the physicians were not always responding to the recommendations.	F 428		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (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	F 441	INFECTION CONTROL, PREVENT SPREAD, LINENS Corrective Actions LPN#1 will be re-educated on the proper Infection Prevention techniques while providing wound care with gloves, by the Infection Prevention Nurse/designee; on or before 12/29/17. Resident #158 is receiving wound care utilizing appropriate Infection Prevention techniques. Resident #10 & #121 are being transferred with an individually assigned sit to stand sling; the sit to stand mechanical lift is being disinfected between resident uses.	12/29/17

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F 441	Continued From page 54 implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (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	F 441	Others Potentially Affected All residents have the potential to be affected by this practice. Systemic Changes Nursing staff will be educated on Infection Control and Prevention, with specific focus areas of: • Cleaning mechanical lifts between resident uses • Individualized resident sling assignment for all sling and lift types • Proper glove use and hand hygiene DisInfecting wipes (EPA approved) will be mounted to each mechanical lift for ease of staff use in cleaning lifts. Monitoring Weekly audit by IPN/designee on mechanical lift cleaning between resident uses, individually assigned resident slings for mechanical lifts, and proper glove hand hygiene use. Audit findings will be reported to the QAPI Committee for analysis and recommendations, until the committee determines that compliance has been met and sustained.	

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F 441	Continued From page 55 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 and procedure review the facility failed to ensure proper infection prevention measures were followed during 3 random observations. The following concerns were identified: 1. On 11/15/17 at 2:33 PM observation of wound care for a pressure ulcer on resident #158 showed LPN #1 donned gloves and removed the old dressing, and cleansed the wound. Without taking these dirty gloves off or performing hand hygiene the LPN reached into a tray of clean dressing supplies. 2. Observation on 11/14/17 at 9:15 AM showed CNAs #2 and #3 assisted resident #10 from his/her bed to a wheelchair with a sit-to-stand mechanical lift. CNA #3 then removed the lift and sling from the room and parked it in a common area across from a doctor's visitation room. The lift and sling were observed until 11:33 AM, and were not cleaned or disinfected after use. 3. Observation on 11/14/17 at 11:50 AM of a resident transfer revealed the following: a. 2 CNAs put a sling around the resident #121 and used a sit-to-stand mechanical lift to	F 441		

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F 441	Continued From page 56 transfer resident. b. The CNAs removed the sling from the resident, placed the sling on the mechanical lift and wheeled the lift to the hall without any disinfection. c. The base of the lift where the resident stood was visibly soiled with debris. d. Observation on 11/16/17 at 12:00 PM revealed the mechanical lift remained with the debris in an unclean condition. 4. Interview on 11/16/17 at 1:10 PM with RN #3 stated the expectation when going from dirty to clean "was to remove dirty gloves, wash hands, get clean supplies, put clean gloves on and continue doing wound care." She also confirmed equipment such as a lift was to be "wiped after resident use." She further stated if it was "grossly contaminated with blood, the night shift is supposed to wipe down equipment." She revealed they were "working on putting together a cleaning list." 5. Review of the Handwashing/Hygiene Policy & Procedure dated 2013 stated, "Hand hygiene needs to be completed...after contact with blood, body fluids, visibly contaminated surfaces or contact with objects in the resident's room. 6. Review of the Cleaning and Disinfection Policy dated 2014 stated "Supplies and equipment will be cleaned immediately after use..."	F 441		
F 468 SS=D	CORRIDORS HAVE FIRMLY SECURED HANDRAILS CFR(s): 483.90(i)(3) (i)(3) Equip corridors with firmly secured handrails on each side; and	F 468	CORRIDERS HAVE FIRMLY SECURED HANDRAILS Corrective Actions The handrails on the West Station hallway have been securely fastened, between rooms #39 and #40, and beside room #35. Others Potentially Affected No other residents were affected by this practice.	12/29/17

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F 468	Continued From page 57 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure handrails were securely fastened to the wall on 1 of 4 resident hallways (West Station). The findings were: Observation on 11/15/17 at 4:17 PM revealed the handrails beside room #35 and between rooms #39 and #40 were loose and not firmly secured to the wall. Interview on 11/16/17 at 11:35 AM with the Maintenance Director and Administrator revealed they were not aware of the loose handrails and confirmed they required maintenance to secure them to the wall for resident safety.	F 468	**Systemic Changes** Handrails will be added to the monthly TELS maintenance check system, on or before 12/29/17. Maintenance staff will be educated on the need to routinely check for fastened handrails throughout the facility. Education will be completed on or before 12/29/17. **Monitoring** Weekly audit for hand rail safety to be completed by the Maintenance Director/designee. Audit findings will be reported to the QAPI Committee for analysis and recommendations. Audits will continue until the committee determines that compliance has been met and sustained.	
F 520 SS=E	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must :	F 520	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS **Corrective Actions** The facility has implemented an effective quality assessment and assurance program to identify and correct facility concerns previously identified; and evaluate or change the plan through the quality assessment and assurance committee. Previously cited areas of concerns include F241, F244, F253, F282, F309, F312, F314, F353, F371, F441 and F520. **Identification:** No residents were adversely affected by the current practice.	12/29/17

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(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 520	Continued From page 58 (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview, and provider survey history report, the facility failed to implement an effective quality assessment and assurance (QAA) program to sustain compliance with previously identified deficiencies in a variety of areas. The findings were: Review of the Casper 3 report dated 11/3/17 showed the facility had a history of repeated deficiencies. The data showed citations from 6/2013, 8/2014, 10/2015, and 10/20/16 which had been cited multiple years. The repeated deficiencies included: F241, F244, F253, F282, F309, F312, F314, F353, F371, F441 and F520. These deficiencies were also found to be out of compliance during the current survey dated	F 520	Systemic Changes: The Administrator and Director of Nursing will be re-educated on having an effective quality assurance program. IDT team will be in-serviced on the new Requirements of Participation related to QAPI in Nursing Home Facilities on or before 12/29/17. This will include emphasis on monitoring, identifying, and developing performance improvement plans to correct current and ongoing issues via the QA&A committee. The facility staff will be in-serviced on or before 12/29/17 on Quality Assurance, QAPI, and the importance of recognizing as well as reporting to supervisors any current or ongoing issues in the facility. The facility has changed its focus from not only quality assurance, but to also including a more systematic approach to performance and sustaining improvement. (QAPI) Quarterly Quality Assurance Performance Improvement meetings will be held at regular intervals with all required staff members involved. Monitoring Performance improvement plans developed to correct concerns identified will be reviewed and updated for effectiveness at the next Quarterly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535042	A. BUILDING _____ B. WING _____	C 11/16/2017

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F 520	Continued From page 59 11/16/17. Interview with the facility administrator and DON on 11/16/17 at 4:45 PM revealed the QAA program continued to work on many areas. The administrator stated the plans of correction were based on the specific situations for each citation and therefore did not always ensure the tag would not be cited again for a different scenario under a requirement.	F 520		