STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535025	A. BUILDING _____ B. WING _____	C 07/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEYENNE HEALTH CARE CENTER	2700 E 12TH STREET CHEYENNE, WY 82001

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Healthcare Licensing and Surveys from 7/9/18 to 7/16/18. Also reviewed in the course of the survey were complaint intakes WY000002646, WY000002645, WY000002622, WY000002616, WY000002614, WY000002605, WY000002656, WY000002657, WY000002659, and WY000002660. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living CNA- Certified Nurse Aide DON- Director of Nursing Services MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 573 SS=D	Right to Access/Purchase Copies of Records CFR(s): 483.10(g)(2)(i)(ii)(3) §483.10(g)(2) The resident has the right to access personal and medical records pertaining to him or herself. (i) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours	F 573		8/23/18

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

Electronically Signed | 08/09/2018

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.

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F 573	Continued From page 1 (excluding weekends and holidays); and (ii) The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of: (A) Labor for copying the records requested by the individual, whether in paper or electronic form; (B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and (C)Postage, when the individual has requested the copy be mailed. §483.10(g)(3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in paragraph (g)(2) of this section may be made available to the patient at their request and expense in accordance with applicable law. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, staff interview, and interview with local businesses, the facility failed to ensure a reasonable, cost-based fee was imposed for copies of the medical record for 2 of 2 requests reviewed. The findings were: 1. Review of the "Authorization Form for Release of Information" showed a request from the	F 573	Preparation and/or execution of this plan of correction do not constitute admission of agreement by the provider as to the validity of the assertions set forth in the statement of deficiencies. The plan of correction is	

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F 573	Continued From page 2 representative of resident #143 for the "complete record from date of admission to date of discharge". The request was dated 3/15/18. Review of the billing statement showed the charges included $18.53 ($1.83 a copy) for the first 10 pages, $25.50 for the next 30 pages ($.85 a copy), and $272.46 ($.57 a copy) for the next 478 pages. The bill also included a reverse charge of $1.14 for two blank pages. The total of the bill was $315.35. 2. Review of a request for medical records from an insurance agency for discharged resident #146 showed a request for hospital notes was submitted on 4/7/18. Review of the billing statement showed the charges included $18.53 for the first 10 pages and $8.50 for the next 10 pages. The total of the bill was $27.03. 3. Interview on 7/12/18 at 11:26 AM with the business office manager revealed the price for copying a medical record was determined by the corporation. Interview on 7/16/18 at 3:33 PM with the administrator revealed Wyoming did not have a state statute that defined a "reasonable fee" so the corporation used guidelines set by the state of Colorado since it was in the same geographical area. 4. Review of the policy "Release of Protected Health Information (Medical Record Requests)" with a revision date of June 2015 showed "...7. The facility will charge a fee for producing copies of resident's record, in accordance with State law and community standards as prescribed by the applicable State statute..." 5. Interview on 7/13/18 with 3 local businesses that provided copying services revealed the	F 573	prepared and/or executed solely because it is required by the provisions of Federal and State Laws. F 573 Corrective Action Resident # 143 no longer resides in the facility and a check request was submitted for reimbursement of the difference between the original rate charged for copies and the new rate on 8/8/18. Resident # 146 no longer resides in the facility. A check request was submitted for reimbursement to the insurance company for the difference between eh original rate charged for copies and the new rate. Corrective Action The Medical Records Director audited all records requests for last 30 days for charges for records. None were found. Systemic Change The facility contacted other medical facilities in the state in order to determine what other facilities charge for copies. Based on the findings the facility adjusted the charges for copies of the medical record. In-service education was provided to the Medical Records Director regarding the changes in the rates.	

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F 573	Continued From page 3 following: a. Interview with business #1 at 12:24 PM revealed the highest fee for full-service copying, which included labor and supplies was $.15 per page. b. Interview with business #2 at 12:30 PM revealed the highest fee for full-service copying was $.13 per page. c. Interview with business #3 at 12:35 PM revealed copies could be made at that location for $.10 per page.	F 573	Monitoring The Medical Records Director records requests as they come in and documents the number of pages. The tracking is then submitted to the QAPI Committee monthly for their review and further recommendations.	
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records.	F 583		8/23/18

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F 583	Continued From page 4 (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on resident interview and staff interview, the facility failed to ensure residents received mail on Saturday. The facility census was 96. The findings were: 1. Interview with a group of 8 residents on 7/10/18 at 10 AM revealed that while they received mail on weekdays, they did not receive mail on Saturday. 2. Interview on 7/11/18 at 3:11 PM with the activities assistant revealed during the week she obtained mail from the front desk and delivered it to the residents. She also stated when she gathered mail from the front desk assistant on Monday, the assistant told her, "Here's the weekend mail." 3. Interview on 7/11/18 at 3:42 PM with the front desk assistant revealed mail delivered on Saturdays was placed in a black box labeled "Weekend Mail." On Monday morning she opened the box, retrieved the mail, sorted it and delivered it to the activities assistant, who dispersed it to residents.	F 583	F583 Corrective Action Weekend mail delivery began on Saturday 7/28/18. Identification of Others All residents who receive mail at the facility have the potential to be affected by this practice. The System change will correct the deficiency for all residents. Systemic Change The activity staff and the weekend nursing supervisor were provided keys to the locked mail box in order to have access to the mail on the weekend. The activity staff retrieves the resident□s mail and delivers the mail on the day that it is delivered to the facility. If the mail is not delivered to the facility before 5:00 PM the activity staff notifies the nursing supervisor to deliver the resident□s mail when it is	

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F 583	Continued From page 5	F 583	delivered to the facility. In-service education was provided to the activity and the nursing supervisor by the NHA on 7/23/18 related to ensuring mail delivery on the weekend. Ongoing Monitoring The Administrator checks for weekend mail delivery weekly to ensure that the resident mail is delivered to residents on the day that it is received in the facility and document the findings. The Administrator will submit the findings from the audits to the monthly QAPI Committee meeting for review and any further recommendations.	
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		8/23/18

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F 623	Continued From page 6 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;	F 623		

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F 623	Continued From page 7 (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by:	F 623		

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F 623	Continued From page 8 Based on medical record review and staff interview, the facility failed to ensure a transfer notice was issued to 8 of 8 sample residents with hospital transfers (#21, #24, #39, #77, #81, #85, #95, #248). The findings were: 1. Review of the medical record showed resident #21 was transferred to the hospital on 3/17/18 for a post-fall assessment. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 2. Review of the medical record showed resident #24 was transferred to the hospital on 6/26/18 for a medical procedure. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 3. Review of the medical record showed resident #39 was transferred to the hospital on 2/22/18, 3/18/18, and 4/30/18 for acute changes of condition. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 4. Review of the medical record showed resident #77 was transferred to the hospital on 5/10/18 for an acute change of condition. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 5. Review of the medical record showed resident #81 was transferred to the hospital on 6/22/18 and returned on 6/24/18. Further review showed no evidence that the facility issued a written notice of transfer to the resident or the resident's	F 623	F623 Corrective Action Resident and family of #21, #24, #77 and #85 were provided an informational copy of the transfer/discharge notice on 8/7/18. Resident□s # 39, #81, #95 and #248 have been discharged from the facility. Identification of Others An audit was conducted of transfer/discharges in the last 30 days and informational notices were provided to any resident identified. Systemic Changes At the time of discharge or transfer the licensed nurse completes the transfer/discharge notice with all of the required information and gives to the resident/family. The nurse documents that the notice was provided in the resident record. Prior to 8/9/18 the Staff Development Coordinator provided the Licensed Nurses and Social Services in-service training regarding the process and regulation that residents receive a written notice of transfer and/or discharge. Monitoring Social Services completes daily audits (M-F) for 4 weeks, followed by monthly for	

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F 623	Continued From page 9 representative. 6. Review of the medical record showed resident #85 was transferred to the hospital on 6/17/18 for an acute change of condition. Further review showed no evidence the facility issued a written notice of transfer to the resident or the resident's representative. 7. Review of the medical records showed resident #95 was transferred to the hospital on 4/19/18 and returned on 4/20/18. Further review showed no evidence that the facility issued a written notice of transfer to the resident or the resident's representative. 8. Review of the medical record showed resident #248 was transferred to the hospital on 10/15/17 and returned on 10/28/17. On 11/3/17 the resident was transferred to the hospital and returned on 11/7/17. Further review showed no evidence that the facility issued a written notice of transfer to the resident or the resident's representative. 9. Interview on 7/12/18 at 10:40 AM with the district clinical director and the DON revealed the facility did not issue a written notice of transfer for residents who were sent to the hospital.	F 623	3 months on residents that were transferred or discharge to validate compliance with process of residents receiving a written notification of transfer and/or discharge. The Director of Nursing will submit the findings from the audits to the monthly QAPI Committee meeting for review and any further recommendations.	
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to	F 625		8/23/18

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F 625	Continued From page 10 the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide written information on the bed-hold policy for 8 of 8 sample residents (#21, #24, #39, #77, #81, #85, #95, #248) reviewed for transfers. The findings were: 1. Review of the medical record showed resident #21 was transferred to the hospital on 3/17/18 for a post-fall assessment. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative. 2. Review of the medical record showed resident	F 625	F625 Corrective Action Resident and family of #21, #24, #77 and #85 were provided an informational copy of the Bed Hold notice on 8/7/18. Resident□s # 39, #81, #95 and #248 have been discharged from the facility. Identification of Others A an audit was conducted of discharged residents in the last 30 day to identify any	

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F 625	Continued From page 11 #24 was transferred to the hospital on 6/26/18 for a medical procedure. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative. 3. Review of the medical record showed resident #39 was transferred to the hospital on 2/22/18, 3/18/18, and 4/30/18 for acute changes of condition. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative. 4. Review of the medical record showed resident #77 was transferred to the hospital on 5/10/18 for an acute change of condition. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative. 5. Review of the medical record showed resident #81 was transferred to the hospital on 6/22/18 and returned on 6/24/18. Further review showed no evidence that the facility issued a written notice of a bed hold to the resident or the resident's representative. 6. Review of the medical record showed resident #85 transferred to the hospital on 6/17/18 for an acute change of condition. Further review showed no evidence the facility issued a written notice of the bed-hold policy to the resident or the resident's representative. 7. Review of the medical records showed resident #95 was transferred to the hospital on 4/19/18 and returned on 4/20/18. Further review showed no evidence that the facility issued a written	F 625	resident discharged without a Bed hold notice. Any identified residents were provided an informational copy. Systemic Changes The nurse that discharges a resident to the hospital or therapeutic leave will send the bed hold authorization with the transfer/discharge form with the resident. A copy will go to the business file and a copy in the medical record. The nurse will document that the bed hold policy went with the resident. The Business Office/social services will do a follow-up call regarding the bed hold. Prior to 8/9/18 the Staff Development Coordinator provided in-service training for the Licensed Nurses and Social Services regarding the regulation and procedure for bed holds including required documentation. Monitoring Social Service Director completes audits on residents that were discharged or on therapeutic leave weekly for 4 weeks, followed by monthly for 3 months to validate compliance with the regulation and procedure for bed hold. Social Services submits the findings from the audits to the monthly QAPI Committee meeting for review and further recommendations.	

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F 625	Continued From page 12 notice of a bed hold to the resident or the resident's representative. 8. Review of the medical record showed resident #248 was transferred to the hospital on 10/15/17 and returned on 10/28/17. On 11/3/17 the resident was transferred to the hospital and returned on 11/7/17. Further review showed no evidence that the facility issued a written notice of a bed hold to the resident or the resident's representative. 9. Interview on 7/12/18 at 10:40 AM with the district clinical director and the DON revealed the facility did not issue a written notice including the bed hold policy for residents who were sent to the hospital.	F 625		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on incident report review, medical record review, and staff interview, the facility failed to ensure the care plan was implemented to prevent falls for 1 of 5 sample residents (#85) reviewed for falls. This failure resulted in past non-compliance at actual harm to resident #85 who fell and experienced a leg fracture. Corrective measures were implemented by the	F 689	Past noncompliance: no plan of correction required.	8/9/18

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F 689	Continued From page 13	F 689		

facility prior to the survey and compliance was determined to be met on 7/6/18. The findings were:

1. Review of the significant change MDS assessment dated 4/26/18 showed resident #85 was admitted with diagnoses which included arthritis and Alzheimer's disease. Review of the care plan with a review date of 5/15/18 showed the resident required the extensive assistance of 2 staff for dressing, bed mobility and transfers. The following concerns were identified:

a. Review of the incident/accident report dated 6/17/18 and timed 6:20 AM showed "Resident slid off the air mattress when a staff member was pulling her pants up...[staff member] was able to lift her into her chair from a falling position to keep her off the floor. Resident's right foot was turned to the right and dangling..." Review of the nursing progress notes dated 6/17/18 and timed 11:51 AM showed, "CNA was dressing the lower extremity of the resident when resident began to fall. CNA was able to get the resident into a nearby chair. CNA noted something was wrong with the resident's lower extremity and ran out to get the nurse... The resident was sent to the emergency room for evaluation... " Review of the nursing notes dated 6/19/18 and timed 12:52 AM showed the resident had "a fall with major injury of non-displaced fracture of tibia and fibula..."

b. Interview on 7/12/18 at 10:54 AM with the DON revealed the care plan carried through to the Kardex (a medical information system used by nursing staff as a way to communicate important information about their residents) which the CNAs reviewed for resident care. She also stated her expectation was for CNAs to follow the Kardex. In addition, she confirmed, only one staff

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F 689	Continued From page 14 member dressed the resident that day and she was not sure why the care plan was not followed. c. Interview on 7/13/18 at 11:12 AM with CNA #1 revealed she dressed the resident without assistance and the resident fell out of bed. She further revealed she did not look at the Kardex and thought the resident only required 1 staff member for assistance with dressing. 2. Review of the facility's "Action Plan" and interview with the corporate nurse, the administrator, and the DON on 7/16/18 at 4 PM revealed the facility implemented corrective actions to prevent re-occurrence. The actions taken by the facility included: a. Identified other residents by conducting an audit on transfer assessments for completion and accuracy. All current residents received a new fall assessment. The care plans and Kardex information for residents were reviewed and updated as needed. b. Staff were educated on the following: lift and transfer policy, reviewing the Kardex for resident needs, abuse and neglect prohibition, and fall management and prevention. Staff also performed return demonstration on 1-person and 2-person transfer using the gait belt, the sit-to-stand and the mechanical lift. Staff also received education on inflating air beds for care. c. Monitoring was accomplished by performing a review of completed transfer assessments for completion, during clinical meetings. Incident/accident reports were reviewed daily at the stand up meeting. Falls were reviewed at the weekly risk meeting to ensure interventions were appropriate and the plan of care was followed. d. An ad hoc QAPI meeting was held on 6/22/2018.	F 689		

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F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of pharmacy account information, review of destruction logs, and staff interview, the facility failed to ensure an effective process for	F 755	F755 Corrective Action	8/23/18

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F 755	Continued From page 16 destruction/disposition of discontinued narcotic medications for 1 of 5 sample residents (#144) reviewed for medication destruction. The findings were: Review of the August 2017 medication administration record (MAR) showed resident #144 was admitted to the facility on 8/10/17. The record showed the resident had medical conditions which included pain in the right and left leg, an unspecified wrist, the low back, and the left shoulder. An order for the narcotic pain medication Norco 5-325 mg 1 tablet every 6 hours as needed was dated 8/11/17. The MAR showed the medication was administered to the resident related to pain once on 8/11, twice on 8/12, twice on 8/13, and once on 8/14. Review of an 8/15/17 signed order showed the Norco was discontinued. The following concerns were identified: a. Review of the 12/25/17 "Statement of Account" from the pharmacy for this resident showed on 8/11/17 hydrocodone-acetaminophen 5mg-325mg (the generic form of Norco) was charged to the account. The quantity for Norco shown on one line was 86, and another line showed a quantity of 4 tablets which were charged. b. Review of the August 2017 destruction logs for this resident failed to show any record of the Norco. c. Interview on 7/16/18 at 4:24 PM with the district clinical director and the senior director of regulatory compliance verified there was no narcotic destruction log of this resident's Norco. d. Interview with the DON on 7/9/18 at 4:50 PM revealed she was responsible for removing discontinued medications. The process for discontinued controlled medications included	F 755	Resident #144 no longer resides at the facility. The Narcotic destruction records were located on 7/30/18. Identification of Others All residents have the potential to be affected by this practice. On 8/9/18 the DON completed a review of the current narcotic to be disposed to ensure all are in compliance. Systemic Change The Pharmacy Consultant provides in-service training for the Director of Nursing regarding narcotic medication destruction process on 8/9/18. The DON and the pharmacist or another RN received the medications off the medication cart and double sign the medication sheet and the narcotic sheet. Narcotic are destroyed when they are removed from the cart. The narcotics are then recorded onto the narcotic destruction log. The original narcotic sheets is sent to Medical Records for filing. Monitoring During the Pharmacy Consultant weekly visit a written review of narcotic destruction will be included to validate in compliance. The outcome of the reviews will be	

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F 755	Continued From page 17 retrieval of the medication card from the medication cart and the documents located in the narcotic log book. She documented in the narcotic log book she removed the medication. The narcotic and the count card were placed in a double-locked file cabinet in her office, however, no log was kept of the file cabinet contents. Each month she listed the medications from the file cabinet with the pharmacist and the controlled medications were then destroyed. The DON further stated she started her job in November and she did not have a record or knowledge of the medications for resident #144.	F 755	submitted to the monthly QAPI Committee meeting for review and further recommendations.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy and procedure review, and review of professional standards, the facility failed to maintain a medication error rate of five percent or less. The error rate for medication administration pass was 4 errors out of a possible 33 opportunities resulting in a 12.12 percent error rate. The findings were: Observation during medication administration on 7/12/18 at 7:43 AM, showed LPN #1 crushed Tylenol 650 milligram (mg) tablet, Atorvastatin 40 mg tablet, Baclofen 10 mg tablet, and Venlafaxin 75 mg tab together and administered the mixed, crushed medications with water through resident	F 759	F759 Corrective Action R# 24 continues to reside in the facility. The physician□s orders for administration via gastrostomy tube were corrected to meet standards of nursing practice. LPN #1 was provided in-service education related to administering medication via a gastrostomy tube. Identification of others	8/23/18

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F 759	Continued From page 18 #24's PEG tube. The following concerns were identified: a. Interview on 7/12/18 at 9:15 AM with LPN #1 confirmed the four tablets were crushed and given together. b. Review of the policy titled, "Omnicare medication administered through an Enteral Tube" with an effective date 10/31/16 showed: "...1. Medications are administered as prescribed in accordance with standard nursing principles and practices... ...6. Facility should administer each medication separately and flush the tubing between each medication administered." c. According to "Nursing Interventions and Clinical Skills" by Perry, Potter, and Ostendorf (2016), sixth edition: "Implementation for Administering Medications Through A Feeding Tube...13...b. To administer more than one medication, give each separately and flush between medications with 30 to 60 mL of water..."	F 759	A review of the current resident□s physician□s orders was conducted to identify other residents that require medications administered via a gastrostomy tube. Any other residents identified, orders were corrected to meet standards of nursing practice. Systemic Changes Staff Development Coordinator provided in-service training for licensed nurses regarding administering medication via a gastrostomy tube. Staff Development Coordinator conducted medication pass competencies on Licensed Nurses. Monitoring Medication observations are conducted randomly on 3 nurses weekly by the SDC/designee to ensure that medications are being administered via the gastrostomy tubes according to the standards of nursing practice. These observations will be conducted weekly for 4 week and then monthly for the following 2 months. The Director of Nursing will submit the outcome of the ongoing monitoring to the monthly QAPI Committee meeting for review and further recommendations.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		8/23/18

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F 761	Continued From page 19 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, manufacturer instructions, and policy and procedure review, the facility failed to ensure medications available for use were not expired in 1 of 2 medication carts (southeast cart). The findings were: 1. Observation on 7/12/18 at 8:43 AM of the southeast medication cart showed one Novolog FlexPen 100 unit/milliliter syringe with an open date of 6/7/18.	F 761	F761 Resident Specific The Novalog Flexpen was immediately disposed on 7/12/118. A new insulin pen was order from the pharmacy. Identification of others All other residents that have orders for insulin pens were verified to be in	

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F 761	Continued From page 20 2. Interview on 7/12/18 at 9:15 AM with LPN #1 confirmed the medication was expired and still available for use. 3. Review of manufacturer's instructions found at www.rapidactinginsulin.com/novolog/using-novolog/storage-and-handling.html (retrieved 7/17/18) showed opened Novolog FlexPens could be used for up to 28 days. 4. Review of the policy titled "Omnicare insulin storage" last revised on 3/31/17, showed a recommendation of 28 days of use. Review of the "Medication Administration policy" last revised June 2008 included: ..."9. Follow the medication/pharmacy guidelines for storage..."	F 761	compliance with expiration dates on 8/7/18. Systemic Changes Prior to 8/9/18 the Staff Development Coordinator provided the Licensed Nurses with in-service education regarding checking insulin and insulin pens for expiration dates during their medication count. Ongoing Monitoring SDC completes audits weekly for 4 weeks followed by monthly x 3 months on residents with physician orders to receive insulin an insulin pens to validate in compliance with expiration dates. The Director of Nursing will submit the findings of the audits to the monthly QAPI Committee meeting for review and further recommendations.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(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. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		8/23/18

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F 812	Continued From page 21 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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation review of product label, and staff interview, the facility failed to ensure food was stored/prepared under sanitary conditions in 1 of 1 kitchens. In addition, the facility failed to ensure thickened fluids were appropriately stored in 2 random resident rooms. The findings were: 1. Observation of the kitchen on 7/9/18 at 10:14 AM showed the hood system located above the range and grill had accumulated grease that was forming drops along the edge. There was also visible grease build-up in the removable vents. Observation on 7/11/18 at 4:30 PM showed the grease continued to drip off the edge of the hood. 2. Observation on 7/9/18 at 10:14 AM showed there was black dust build-up on the fan and surrounding ceiling area in the walk-in refrigerator. 3. Interview on 7/12/18 at 8:30 AM with the facility dietary manager and the district dietary manager verified the issue with the hood and grease was ongoing and it dripped due to a maintenance issue. The cleaning list showed cleaning the hood vents was on the weekly list. 4. According to Food Code 2017, U.S. Public	F 812	F 812 Corrective Action The kitchen hood was cleaned on 7/16/18 and repaired on 8/2/18. The dust build-up on the fan and surrounding ceiling area in the walk-in refrigerator was cleaned on 7/24/18 and the covers to the fans replaced on 8/2/18. The thickened water for the resident in room #140 B and the resident in room #112 B was disposed of on 7/13/18. Identification of Others All residents have the potential to be affected by a kitchen hood and the walking fans that require cleaning. The Director of Nursing obtained a list of residents with orders for thicken water. The identified residents have bedside coolers for thicken water throughout the day. The system change will correct the	

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F 812	Continued From page 22 Health Service: 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. Related to storage of thickened liquids: 1. Observation on 7/12/18 at 9:04 AM showed the resident near the window in room 140 had a small soft-sided cooler located on the bedside table. Inside the cooler was an ice pack and 2 plastic cups containing thickened water. The label on the lids of the water showed the date "7/13/18." The ice pack was cold; however, the cooler did not contain a thermometer. 2. Observation on 7/13/18 at 9 AM showed the resident near the window in room 112 had a small soft-sided cooler located on the bedside table. Inside the cooler was an ice pack and 2 plastic cups containing thickened water. The label on the lids of the water showed " in 7/13/18 ex. 7/15/18." The ice pack was cold; however, the cooler did not contain a thermometer. 3. Review of the thickened water product label showed it was good for 8 hours in ambient air temperature, or up to 7 days if refrigerated. 4. Interview with the district director of dining services on 7/16/18 at 12:10 PM verified the facility's system did not ensure these items were stored at a refrigerated temperature or were marked to ensure they would be discarded after 8 hours.	F 812	deficiency for all residents. Systemic Change The Maintenance Staff were provided in-service training on 8/8/18 by the administrator regarding the requirement of quarterly cleaning of the kitchen hood and walk-in fans. The Licensed Nurse provide new thicken water every 8 hours per the physician□s order and place it in the cooler at the resident□s bedside. The Licensed nurse puts the date and time and initials the cup lid. Prior to 8/9/18 the Staff Development Coordinator provided in-service training to the licensed nurses related to the process for providing thickened water at the bed side. Ongoing Monitoring The Maintenance Director checks the date posted on the hood in the kitchen monthly as part of the ongoing preventative maintenance of the equipment and documents his findings. He schedules the quarterly cleaning 2 months after the date of the last cleaning to ensure that the hood is professionally cleaned quarterly. The fans in the walk-in cooler have been placed on a quarterly cleaning schedule with a professional vendor. The Maintenance Director checks the fans at	

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	535025	A. BUILDING _____ B. WING _____	C 07/16/2018

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F 812	Continued From page 23	F 812	the 2 month mark from the last cleaning and schedules the quarterly cleaning. The Care Management Director will complete observation rounds to ensure thicken water is in coolers with date and time on them. The Maintenance Director will submit the findings of the audits to the monthly QAPI Committee meeting for review and further recommendations. The Director of Nursing will submit the findings from the observation rounds to the monthly QAPI Committee meeting for review and any further recommendations.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(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: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		8/23/18

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F 880	Continued From page 24 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; §483.80(a)(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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 25 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure effective infection control practices were followed for 1 of 3 residents (#39) with a catheter. The findings were: Observation on 7/9/18 at 11:06 AM showed resident #39 was in bed and his/her catheter bag was lying directly on the floor. Observation on 7/10/18 at 8:31 AM showed CNA #2 transferred the resident from his/her wheelchair to the bed and then removed the catheter bag from the wheelchair and attached it to the frame of the bed. However, the catheter bag was placed so it sat directly on the floor. Observation on 7/10/18 at 4:22 PM showed the catheter bag was in a blue cover bag and was resting directly on the floor. Observation on 7/12/18 at 8:03 AM with the infection preventionist and the district clinical director showed the catheter bag was again lying directly on the floor. Interview at that time with the district director confirmed the catheter bag should have been placed in a basin.	F 880	F880 Corrective Action Resident #39 no longer resides in the facility. The catheter collection bag was place in a basic to lift off the floor due to the low bed. Identification of others The Director of Nursing and Unit Managers completed a review of physician□s orders for residents with an indwelling catheter. The residents with an indwelling catheter that have a low bed the collection bag was placed in a basin. Systemic Change Residents with catheter drainage bags and who are required to have their bed in the lowest position have a basin provided to place the drainage bag in to prevent the drainage bag from touching the floor. Prior to 8/9/18 the Staff Development Nurse provided the nursing staff with in-service training regarding infection control	

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F 880	Continued From page 26	F 880	practices for residents with indwelling catheter collection bags. Monitoring Licensed nurses will complete observation rounds to ensure catheter collection bags are not resting on the floor. The Director of Nursing will submit the findings to the monthly QAPI Committee meeting for review and any further recommendations.	
F 924 SS=D	Corridors have Firmly Secured Handrails CFR(s): 483.90(i)(3) §483.90(i)(3) Equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 2 random handrails (southeast hall, southwest hall) were firmly affixed. The findings were: 1. Observation on 7/9/18 at 11:15 AM showed an unidentified resident using the hand rail to wheel him/herself down the hall, and the rail pulling away from the wall near room 122. Observation on 7/9/18 at 11:18 AM showed 2 brackets that secured the hand rail to the wall near room 122 where broken. 2. Observation on 7/10/18 at 4:11 PM revealed 1 bracket that secured the hand rail to the wall near room 103 was broken. 3. Interview on 7/13/18 at 10:40 AM with the maintenance supervisor confirmed these hand	F 924	F 924 Corrective Action The identified handrail on the South Unit was corrected immediately by the Maintenance Assistant on 7/10/18. Identification of others 100% of the handrail in the facility was inspected by the Maintenance Assistant on 7/27/18 any identified loose handrail was repaired immediately. Systemic Change Prior to 8/9/18 in-service education was provided to the facility staff regarding the	8/23/18

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F 924	Continued From page 27 rail brackets were broken and needed repair.	F 924	importance of reporting and ensuring that the handrail is secure and in working order at all times. Monitoring The Maintenance Director/designee checks all of the handrail weekly to ensure all of the handrail is functional and secure and documents his findings. These checks will continue weekly for 4 weeks and then be conducted monthly for 3 months. The Administrator submits the findings of the audits to the monthly QAPI Committee meeting for review and further recommendations.	