STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 7/30/18 through 8/2/18. Also reviewed during the course of the survey was complaint intake WY000002670. The following common abbreviations are used through this document: ARD: Assessment Reference Date CMS: Centers for Medicare & Medicaid Services CNA; Certified Nurse Aide DON: Director of Nursing IDT: Interdisciplinary Team MDS: Minimum Data Set OBRA Omnibus Budget Reconciliation Act PTA : Physical Therapy Assistant RAI: Resident Assessment Instrument RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity 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	F 550		9/2/18

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

Electronically Signed | 08/21/2018

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F 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy and procedure review, the facility failed to maintain resident dignity during 1 of 2 meal observations. The findings were: 1. Observation on 7/30/18 at 12:09 PM showed CNA #1 was assisting residents at 2 different tables with eating. The CNA stood next to the residents and offered bites of food then walked to the other table to provide a bite of food to another	F 550	F550 1. The facility will ensure to maintain resident dignity during meal times. 2. All residents are at risk for maintaining resident dignity during meals. Proper assistance will be provided in the dining room during meal times to ensure that residents don't sit without food or fluid	

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F 550	Continued From page 2 resident. Residents sat without food or fluids until the CNA returned to offer another bite. The CNA was assisting a total of 5 residents without assistance. 2. Observation on 7/30/18 at 12:26 PM showed CNA #1 quickly provided multiple bites of food to a resident in a high-back wheelchair. The CNA appeared rushed and provided multiple bites of food before the resident was finished chewing the food that was in his/her mouth. The other residents being assisted received a single bite before the CNA helped another resident. Further observation showed 2 unidentified staff members were standing near the table; however, the staff members did not assist the residents with eating. 3. Interview with the administrator on 8/02/18 at 11:10 AM revealed residents should be assisted by 1 staff member per resident. It would not be expected that a staff member provides physical assistance with meals to 4 residents at a time. Further, the administrator revealed staff should be seated at the resident's level instead of standing in order to make eye contact with residents, evaluate them, and promote resident dignity and safety. 4. Review of the policy titled "Meal Supervision and Assistance" dated 12/1/17 showed "...13. Feed slowly allowing plenty of time between bites...14. provide a relaxing, enjoyable environment during mealtime to make it more to (sic) help the resident eat better..." 5. Review of the policy titled "Maintaining Resident Dignity During Mealtimes" dated 12/1/17 showed "...1. All staff members involved in providing feeding assistance to residents	F 550	while being assisted during meals. 3. Staff will be seated while assisting residents during meal times. 4. Staff will not rush residents while assisting them during meal times. 5. NHA or designee will educate staff on the importance of proper assistance with residents during meal times including but not limited to being seated while assisting residents and not rushing residents during meal times. 6. Audits of meal times will be done randomly through the month (no less than once a month) to ensure proper assistance to all residents will be done for three months or until resolved. The results of the audit will be taken to QAPI.	

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F 550	Continued From page 3 promotes and maintains resident dignity during mealtimes...8. Allow adequate time that the resident requires to complete meal. Do not rush..."	F 550		
F 567 SS=E	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of	F 567		9/2/18

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F 567	Continued From page 4 the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and review of resident council minutes, the facility failed to ensure resident's personal funds were available for resident use. The census was 56. The findings were: 1. Review of the resident council meeting minutes dated 5/24/18 showed the activity department would be holding residents' funds for the weekend if residents needed money. 2. Interview with resident #12 on 7/30/18 at 3:51 PM revealed the facility held his/her money however, the resident stated s/he was unable to get money when the business office manager was not at the facility. 3. Interview with the business office manager on 8/2/18 at 10:21 AM revealed the facility was working on a plan to make money available on the weekends. She confirmed the residents could not get money on the weekends as the plan had not been implemented at that time.	F 567	F567 1. The facility will ensure to provide resident□s personal funds are available for residents use. 2. Resident #12 will be able to get his money when the BOM is not in the facility. 3. All residents that reside at DCC are at risk for not receiving their money on the weekends. All residents will be able to get their money when the BOM is not in the facility. 4. The NHA will educate the BOM, SS and Activities the importance of residents receiving their money when the BOM is out of the facility. 5. Slips will be initiated to give to all residents explaining that if they have a resident trust account through DCC then their funds will be available through the BOM during regular business hours, however if the BOM is out SS is the backup. On weekends, the activities will be able to access resident trust funds for those residents.	

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F 567	Continued From page 5	F 567	6. An audit will be done monthly by the BOM will be done to ensure that our residents can and do have the ability to get their money when the BOM is out of the facility, the audit will be done for three months, the results of the audit will be brought to QAPI until resolved.	
F 623 SS=D	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. §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;	F 623		9/2/18

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F 623	Continued From page 6	F 623		

(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;
(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

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F 623	Continued From page 7 (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: Based on medical record review and staff interview, the facility failed to ensure a transfer notice was issued to 1 of 2 sample residents (#8) who transferred to the hospital. The findings were: 1. Review of a "Progress Note" entry dated 6/13/18 and timed 4:24 PM showed resident #8 was hospitalized related to redness and hardness of the left side of the resident's neck. The following concerns were identified: a. Review of a "Progress Note" entry dated	F 623	F623 1. The facility will ensure a transfer notice is issued for residents who are transferred to the hospital. 2. Resident #8 will have a notice sent from prior hospital stay on 6/13/18. 3. All residents who are transferred are at risk and will have notice of transfers sent to them and/or their representatives at the	

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F 623	Continued From page 8 6/20/18 and timed 1:02 PM showed the resident returned from the hospital. b. Review of the "Progress Notes" between 6/13/18 and 6/20/18 showed no evidence the resident received a written transfer notice from the facility. c. Interview with the administrator on 7/31/18 at 10:45 AM revealed the facility did not issue a written transfer notice to the resident or the resident's representative at the time of the hospitalization.	F 623	time of transfer out of the facility. 4. The NHA or designee will educated the BOM and SS the importance of transfer notices being issued to the representative/resident when the resident is transferred out of DCC. 5. An audit of all transferred residents out of DCC will be done to ensure that a transfer notice was sent out to representative/resident. The audit will be done monthly for three months or until resolved, the results of audit will be brought to QAPI.	
F 625 SS=D	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 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.	F 625		9/2/18

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F 625	Continued From page 9 §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 ensure a a bed hold policy was issued to 1 of 2 sample residents (#8) who transferred to the hospital. The findings were: 1. Review of a "Progress Note" entry dated 6/13/18 and timed 4:24 PM showed resident #8 was hospitalized related to redness and hardness of the left side of the resident's neck. The following concerns were identified: a. Review of a "Progress Note" entry dated 6/20/18 and timed 1:02 PM showed the resident returned from the hospital. b. Review of the "Progress Notes" between 6/13/18 and 6/20/18 showed no evidence the resident received a written bed hold policy from the facility. c. Interview with the administrator on 7/31/18 at 10:45 AM revealed the facility did not issue a bed hold policy to the resident or the resident's representative at the time of the hospitalization.	F 625	1. The facility will ensure a bed hold policy will be issued for all residents who are transferred to the hospital or therapeutic leave. 2. Resident #8 will have a bed hold policy issued for 6/13/18 transfer to hospital. 3. All residents are at risk particularly residents who are transferred to the hospital or on therapeutic leave will have a bed hold policy issued. 4. NHA or designee will educate the BOM and SS the importance of issuing a bed hold policy for residents who are transferred to the hospital or on therapeutic leave. 5. An audit will be done on all residents who are transferred to the hospital or on therapeutic leave have been issued the bed hold policy; the audit will be done monthly for three months or until resolved. The results of the audit will be brought to QAPI until resolved.	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii)	F 636		9/2/18

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§483.20 Resident Assessment
The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication

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F 636	Continued From page 11 with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the CMS RAI version 3.0 manual, the facility failed to ensure a comprehensive assessment was completed not less than once every 12 months for 1 of 1 sample residents (#1) reviewed for missing comprehensive assessments. The findings were: 1. Review of the MDS assessments for resident # 1 showed a significant change assessment was completed and accepted on 6/2/17. Further review showed an annual assessment was completed on 6/3/18; however, the assessment was not submitted or accepted. 2. Interview with the administrator on 8/2/18 at 8:45 AM revealed the assessment was late due	F 636	F636 1. The facility will ensure that a comprehensive assessment will be completed not less than once every 12 months. 2. Resident #1 will have a comprehensive assessment done. 3. All residents that live at DCC are at risk not to have comprehensive assessments done as they are due annually on all residents. All residents will have a comprehensive assessment will be completed not less than once every 12 months.	

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F 636	Continued From page 12 to a change in the MDS coordinator position and the DON position. Further, the assessment was completed; however, she verified the assessment was not submitted. 3. Review of the "CMS RAI version 3.0 manual, October 2017," showed "...The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless a SCSA or a SCPA has been completed since the most recent comprehensive assessment was completed. Its completion dates (MDS/CAA(s)/care plan) depend on the most recent comprehensive and past assessments' ARDs and completion dates..."	F 636	4. The NHA or designee will educated the MDS nurse the importance of ensuring that a compressive assessment is completed not less than once every 12 months. 5. An audit of residents that have their comprehensive assessments due are in fact done. The audit will be done monthly for a minim of three months or until resolved. The results of the audit will be brought to QAPI.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(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 observation, medical record review, staff interview, and review of the CMS RAI version 3.0 manual, the facility failed to ensure a significant change assessment was completed for	F 637	F637 1. The facility will ensure a significant change assessment is completed for	9/2/18

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F 637	Continued From page 13 1 of 3 sample residents (#52) with a change of condition. The findings were: 1. Review of the significant change MDS assessment dated 5/16/18 showed resident #52 had brief interview for mental status (BIMS) score of 3 and diagnoses which included non-Alzheimer's dementia, disorientation, spinal stenosis, and other abnormalities with gait and mobility. The resident was coded to require extensive assistance for bed mobility, transfers, toilet use, dressing, and personal hygiene. Further review showed the resident was at risk for pressure ulcers and did not have any pressure ulcers at the time of the assessment, had no limitation in rang of motion, and no identified weight loss. The following concerns were identified: a. Review of the resident's documented weights showed the resident's weight declined from 184 pounds on 6/6/18 to 172 pounds on 7/2/18, a 6.5 percent weight loss. b. Review of a "Progress Notes" entry dated 7/6/18 and timed 11:58 AM showed "Reviewed at IDT due to wt [weight] change. (See committee record log) I continue on comfort type care with my requests honored. My weight has declined to 172# [pounds]...Due to this wt loss, we will have weekly weights as well as starting medpass TID [three times per day] to minimize [his/her] weight loss. CP [care plan] reviewed adn [sic] updated..." c. Review of a "Progress Notes" entry dated 7/9/18 and timed 4:10 PM showed "...Patient is getting into a flexion contracture at the hips and will benefit from continued therapy work on maintaining full range of motion in [his/her] body..." d. Review of a "Progress Notes" entry dated 7/15/18 and timed 4:29 PM showed "CNA's [sic]	F 637	residents with a change of condition. 2. Resident #52 will have a significant change assessment completed due to weight loss and wound. 3. All residents are at risk for the need of significant change assessments being completed. All residents will have a significant change assessment completed that have a change of condition. A FT MDS nurse has been hired to help ensure that significant change assessments are done. 4. The NHA or designee will educate the Care Plan Team the importance of completing significant change assessments. 5. An audit of all residents who have a significant change will be done to ensure the significant change assessment is done. The audit will be done monthly for three months or until resolved. The results of the audit will be brought to QAPI until resolved.	

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F 637	Continued From page 14 called me to [resident's name] room to show me an area on [his/her] coccyx, two open areas about a dime size each, wound was cleaned and foam padded dressing was applied." e. Interview with PTA #1 8/01/18 at 3:19 PM revealed the coccyx wounds were un-stageable at that time. f. Interview with the MDS coordinator on 8/2/18 at 1:17 PM revealed a significant change assessment should have been completed related to the contractures, weight loss, and pressure areas; however, one was not completed. 2. Review of the "CMS RAI version 3.0 manual, October 2017," showed "...A "significant change" is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "selflimiting"; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan..."	F 637		
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the CMS RAI version 3.0 manual, the facility failed to ensure a quarterly assessment was completed not less than once every 3 months or 92 days for 9 of 26 sample	F 638	F638 1. The facility will ensure a quarterly assessment will be completed not less than once every three months.	9/2/18

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F 638	Continued From page 15 residents (#2, #3, #4, #5, #6, #7, #8, #9, #26). The findings were: 1. Review of the MDS assessments for resident #2 showed the last accepted quarterly MDS assessment was completed on 3/9/18. Further review showed a quarterly MDS assessment was completed, but not submitted or accepted, on 6/9/18. 2. Review of the MDS assessments for resident #3 showed the last accepted quarterly MDS assessment was completed on 3/9/18. Further review showed a quarterly MDS assessment was completed, but not submitted or accepted, on 6/9/18. 3. Review of the MDS assessments for resident #4 showed the last accepted quarterly MDS assessment was completed on 3/9/18. Further review showed a quarterly MDS assessment was completed, but not submitted or accepted, on 6/9/18. 4. Review of the MDS assessments for resident #5 showed the last accepted quarterly MDS assessment was completed on 3/11/18. Further review showed a quarterly MDS assessment was completed, but not submitted or accepted, on 6/11/18. 5. Review of the MDS assessments for resident #6 showed the last accepted quarterly MDS assessment was completed on 3/18/18. Further review showed a quarterly MDS assessment was in process, but not submitted or accepted, on 6/18/18. 6. Review of the MDS assessments for resident	F 638	2. Quarterly assessments will be completed for residents #2, #3, #4, #5, #6, #7, #8, #9, and #26. 3. All residents are at risk for not having quarterly assessments completed. All residents will have quarterly assessments completed not less than once every three months. A full time MDS nurse has been hired to help ensure that all residents have quarterly assessments completed not less than once every three months. 4. The NHA or designee will educate the IDT that all residents need to have quarterly assessments completed not less than once every three months. 5. . An audit will be done weekly to ensure that residents are having quarterly assessments done on time. The audit will be done for six months or until resolved. The results of the audit will be taken to QAPI until resolved. 9/2/18	

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F 638	Continued From page 16	F 638		

#7 showed the last accepted quarterly MDS assessment was completed on 3/19/18. Further review showed a quarterly MDS assessment was completed, but not submitted or accepted, on 6/19/18.

7. Review of the MDS assessments for resident #8 showed the last accepted MDS assessment was an annual assessment completed on 3/16/18. Further review showed a quarterly MDS assessment was completed, but not submitted or accepted, on 6/22/18.

8. Review of the MDS assessments for resident #9 showed the last accepted MDS assessment was an admission assessment completed on 3/26/18. Further review showed a quarterly MDS assessment was completed, but not submitted or accepted, on 6/26/18.

9. Review of the MDS assessments for resident #26 showed the last accepted MDS assessment was a significant change assessment completed on 3/26/18. Further review showed a quarterly MDS assessment was completed, but not submitted or accepted, on 6/26/18.

10. Interview with the administrator on 8/2/18 at 8:45 AM revealed the assessments were late due to a change in the MDS coordinator position and the DON position. Further it was revealed the assessments had been completed; however, the MDS coordinator did not submit the assessments.

11. Review of the "CMS RAI version 3.0 manual, October 2017," showed "...The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be

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F 638	Continued From page 17 completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all MDS items appear on the Quarterly assessment. The ARD (A2300) must be not more than 92 days after the ARD of the most recent OBRA assessment of any type..."	F 638		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(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 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, staff interview, medical record review, and policy and procedure review, the facility failed to ensure pressure ulcers did not develop, or worsen for 2 of 2 sample residents (#50, #52) who were at risk for pressure ulcers. This failure resulted in actual harm to resident #52, who developed an un-stageable pressure injury. The findings were:	F 686	F686 1. The facility will ensure pressure ulcers do not develop or worsen. a. Resident #52 will be placed on a turning schedule every two hours to ensure that resident #52 is not left on his back or sides more than two hours at a	9/2/18

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F 686	Continued From page 18 1. Review of the significant change MDS assessment dated 5/16/18 showed resident #52 had a brief interview for mental status (BIMS) score of 3 and diagnoses which included non-Alzheimer's dementia, disorientation, spinal stenosis, and other abnormalities with gait and mobility. The resident was coded to require extensive assistance for bed mobility, transfers, toilet use, dressing, and personal hygiene. Further review showed the resident was at risk for pressure ulcers, and did not have any pressure ulcers at the time of the assessment. The following concerns were identified: a. Observation on 7/31/18 at 1:44 PM showed 2 CNAs positioned the resident in a shower chair, wrapped the resident in a sheet, and transported him/her down the hall for a shower. Observation at 1:59 PM showed CNA #1 and RN #1 returned the resident to his/her room and used a full body lift to transfer the resident into bed. Observation at that time showed the CNA rolled the resident towards the wall and exposed two wounds to his/her coccyx which were tan and gray in color. There was no wound dressing in place at that time. The CNA positioned the resident on his/her back and placed a pillow under, the resident's back; however, the resident's coccyx remained on the mattress. Continued observation from 2:04 PM until 4:32 PM, 2 hours and 28 minutes, showed the resident remained in the same position while in bed. Observation at 4:32 PM showed CNA #1 and CNA #2 entered the room and assisted the resident up for dinner. CNA #2 rolled the resident toward the wall and exposed the two wounds, which remained without a dressing and continued to be tan and gray in color. b. Review of a "Progress Note" entry dated 7/15/18 and timed 4:29 PM showed "CNA's [sic]	F 686	time. b. A new policy and procedure will be put in place to ensure all residents who are found to have a wound will be picked up on wound rounds with the wound team immediately. Nurses will notify the DON and NHA upon finding a new wound immediately. c. Resident #52 will have the correct MD orders followed on how to treat the wound(s) area. 2. All residents will be placed under the new policy and procedure to ensure all residents who are found to have a wound will be picked up on wound rounds with the wound team immediately. Nurses will notify the DON and NHA upon finding a new wound immediately. 3. . All residents are at risk for pressure ulcers that develop or worsen. All residents' skin will be monitored during shower/bathing times. If there is a skin issue found the charge nurse will be notified immediately. 4. NHA or designee will educate the wound care team and nursing staff the importance of reporting all wounds when they are found, following MD orders for the treatment of the wound and proper documentation of the wound. 5. Wounds will be addressed at weekly weight and skin meetings by the IDT. An audit of new or worsening wounds will be	

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F 686	Continued From page 19 called me to [resident's name] room to show me an area on [his/her] coccyx, two open areas about a dime size each, wound was cleaned and foam padded dressing was applied." c. Review of wound documentation dated 7/26/18 showed the resident had a buttocks wound which measured 1.8 centimeters (cm) by 8 cm, had minimal drainage, and no thickness. The treatment at that time was written as "Polymem [a type of wound dressing] applied after cleaning." d. Review of a physician's order dated 7/25/18 showed "check dressing to coccyx daily and change as need." e. Interview with PTA #1 on 8/1/18 at 3:19 PM revealed that she was unsure why the team did not evaluate the resident's wound until 7/26/18 and the wound was currently un-stageable. Further, she revealed the current order should have been for a polymem dressing to be changed every day and as needed, and a dressing should have been applied following the shower. The PTA stated she would prefer the resident was not placed on his/her back or buttocks when s/he was not in the geri-chair and confirmed the wound appeared to have deteriorated since the original note on 7/15/18. 2. Review of the 3/21/18 quarterly and 5/11/18 significant change MDS assessments showed resident #50 had severe cognitive impairment, and required extensive to total assistance with positioning and transfers. Further review of both assessments showed the resident was at risk for developing pressure ulcers; but did not have any pressure ulcers at the time of the assessments. Review of the 7/15/18 nursing progress notes showed staff provided treatments for an opened quarter-sized pressure ulcer on the resident's	F 686	done weekly for a minimum of three months and the results of that audit will be brought to QAPI for a minimum of three moths or until resolved.	

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F 686	Continued From page 20	F 686		

coccyx. Further review showed no additional information about the appearance of the area. Review of the wound care monitoring documentation showed the wound care team began to monitor the pressure ulcer on 7/26/18. On 8/1/18 at 1:12 PM, RN #1 was observed changing the dressing on a pressure ulcer located on the resident's coccyx. Continued observation showed this wound was open, moist and red. During the dressing change the RN stated the resident was recently changed from a wheelchair to a geri-chair, but she was unsure whether this was after or before the resident developed the pressure ulcer. On 8/2/18 at 10:50 AM, interview with PTA #1 revealed she was responsible for monitoring pressure ulcers. She stated she first became aware of the pressure ulcer on 7/26/18.

3. Review of the policy titled "Pressure Ulcers/Skin Breakdown" dated 6/5/17 showed "...2. In addition, the nurse shall describe and document/report the following: a Full assessment of pressure sore including location, stage, length, width and depth, presence of exudate or necrotic tissue;...4. The physician and wound care team will assist the staff to determine etiology (for example, arterial or stasis ulcer) and characteristics (necrotic tissue, status of wound bed, etc.) of the skin alteration...Cause Identification 1. The physician and wound care team will help identify factors contributing or predisposing residents to skin breakdown;...Treatment/Management 1. The physician and wound care team will authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents if indicated

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F 686	Continued From page 21 for type of skin alteration...2. The physician and wound care team will identify medical interventions related to wound management;..."	F 686		
F 755 SS=E	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	F 755		9/2/18

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F 755	Continued From page 22 by: Based on observation, staff interview, and review of policies and procedures and the facility's investigation, the facility failed to utilize pharmacy services to implement an effective system for preventing drug diversion. This failure resulted in the facility's inability to account for missing medications. The census was 56. The findings were: Interview on 7/31/18 at 3:30 PM with the interim DON revealed staff noted 60 Tramadol 50 milligrams pills were missing on 7/20/18; and during their investigation they noted 60 Hydorcodone 7.5/325 milligram pills were also missing. Review of the facility's investigative findings showed they determine none of the residents were affected by the event; and changes were made in their system for monitoring, ordering, and storing medications. At the time of the survey, the medications were still missing. The following concerns were identified: a. Interview on 08/02/18 at 3:07 PM with RN #2 revealed one of the problems identified with the missing medications was a problem with the facility's system for checking orders. Review of policies and procedures titled "Medication Orders", dated 6/5/17, "Medication Delivery", implemented 7/27/18, and "Controlled Drug Administration Record, updated 7/30/18, showed none included a system for completing periodic audits of medication orders. b. Observation of the medication room on 7/31/18 from 4:49 PM to 5:15 PM with the interim DON showed controlled medications were stored in a plastic bin locked in a cabinet. Interview with the interim DON revealed at that time this supply of narcotics was called the overflow medications and the nurses were	F 755	F755 1. The facility will utilize pharmacy services to implement an effective system for preventing drug diversion. a. Policies and procedures will put in place that includes a system for completing periodic audits of medication orders. b. Overflow of controlled substance will be placed in a second lock box in the each of the med carts so that there are not multiple storage areas. c. There will be a policy, procedure and system put in place to dispose of medications of discharged residents, expired residents and/or dc□d medications that are left over medications. d. There will be a policy, procedure and system put in place for medications that are sent by pharmacy that weren□t ordered, as well as monitoring the mediations until they were returned to the pharmacy. 2. All residents are at risk for drug diversion. There will be cameras installed in and around the nurse's station where medications are stored to help prevent any further issue. 3. Interim DON or designee will educate	

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F 755	Continued From page 23 required to count and sign the narcotics count form each shift, but they did not consistently sign the form or record the quantity of each medication. She stated they planned to move all the controlled medications to the nurse medication carts when the lock boxes that had been ordered arrived. She further stated this would require reconciliation of all controlled substances (the ones in current use and the ones that were currently in the bin) at the same time stored in the same area instead of the current system of monitoring controlled substances in multiple storage areas. c. Observation on 7/31/18 from 4:49 PM to 5:15 PM with the interim DON showed a file cabinet was also located in the medication room. Observation of the file cabinet showed two opened packages; one with 7 unopened vials of Haldol 5 mg/ml, and a second with 13 unopened vials of Haldol 5mg/ml that had been stored among papers and folders in one of the cabinet drawers. Further observation showed one was labeled with the name of a resident who had been discharged and the second with a resident who had expired. At the time of the observation there was no evidence of monitoring for the medications. d. Observation on 7/31/18 from 4:49 PM to 5:15 PM with the interim DON showed an additional medication storage area with expired medications was located in a file cabinet drawer in the DON's office. Observation of the drawer showed boxes of fentanyl patches positioned on top of multiple medication filled bubble pack medication cards and other containers of both non-controlled and controlled medications. Interview with the interim DON revealed the expired medications were placed in the file drawer on 7/25/18 and 7/26/18 for disposal with	F 755	nursing staff of new policies, procedures and systems that include but are not limited to completing periodic audits of medication orders, overflow of controlled substance will be placed in a second lock box in the each of the med carts so that there are not multiple storage areas, disposal of medications of discharged residents, expired residents and/or dc'd medications that are left over medication and medications that are sent by pharmacy that weren't ordered and/or aren't in the EMAR, as well as monitoring the mediations until they were returned to the pharmacy. 4. There will be audits done by the interim DON or designee on medication orders, overflow of controlled substance, disposal of medications of discharged and expired residents as well dc'd medications and medications that are sent by pharmacy and there weren't ordered and/or in the EMAR as well as medications until they are returned to the pharmacy. The audit will be done monthly. 5. The results of the above audits will be done monthly for a minim of three months or until resolved. The results of the audits will be brought to QAPI until resolved.	

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	535040	A. BUILDING _____ B. WING _____	C 08/02/2018

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F 755	Continued From page 24 the "Disposal Buster." She stated there were no records or tracking system for the medications. She further stated the keys to the file cabinet were kept in the business office cash box and only accessible to the billing personnel, the administrator and herself. e. Interview with the pharmacist on 8/1/18 at 3:25 PM revealed the pharmacist had been working with the facility to address some of the problems, but there were still work that needed to be done. f. Interview with RN #3 revealed she was not aware of a system for monitoring medications the pharmacy sent that weren't ordered and have to be returned the following day. Review of the policy and procedures showed no procedure for monitoring the medications until they were returned to the pharmacy.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(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 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a	F 758		9/2/18

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F 758	Continued From page 25 specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to develop a system for ensuring prescribing practitioners indicate the duration for the PRN psychotropic medications and document the rationale for extending the use beyond 14 days. This failure affected 1 of 5 sample residents (#103) reviewed for unnecessary medications. The findings were	F 758	F758 1. The facility will develop a system for ensuring prescribing practitioners indicate the duration for the PRN psychotropic medications and document the rational for extending the use beyond 14 days.	

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F 758	Continued From page 26 Review of the physician's orders for resident #103 showed lorazepam (a psychoactive medication commonly used for the treatment of anxiety disorders) .25 mg (milligram), once a day and "may repeat" 1 time if needed was ordered on 7/4/18. Further review of the order showed a stop date had not been included in the order or a rationale for extending the use beyond 14 days. Review of 2018 Medication Administration Records showed the resident received 23 doses in July 2018. Interview on 8/02/18 at 2:40 PM the interim DON verified the order was open ended and the nurses had not talked with the physician about documenting a rationale for use beyond 14 days.	F 758	2. Resident #103 has expired. 3. All residents are at risk who are prescribed a PRN psychotropic medications will either have the PRN dc'd or there will be rational for extending the use beyond 14 days. 4. The interim DON will educate nursing staff that PRN psychotropic mediations must have practitioners indicate the duration and document the rational for extending the use beyond 14 days. 5. An audit of PRN psychotropic medications will be done monthly for three months or until resolved to ensure that PRN psychotropic mediations are not prescribed more than 14 days or there is rational for extending it beyond 14 days by the prescribing practitioner. The results of the audit will be brought to QAPI until resolved.	
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the lift user manual, the facility failed to ensure a full body lift was in good repair during transfers for 2 of 2 sample residents (#21, #52) who required the use of a full body lift. The findings were:	F 908	F908 1. The facility will ensure the full body lift is in good repair during transfers. 2. Residents #21 and #52 will be transferred with a full body lift in good	9/2/18

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F 908	Continued From page 27 1. Observation on 7/31/18 at 1:59 PM showed CNA #1 and RN #1 assisted resident #52 to transfer from a shower chair to bed. The staff members placed a sling behind the resident and attached it to the full body lift. CNA #1 raised the resident up with the mechanical lift and began to reposition it above the bed. During the lift repositioning, the legs of the mechanical lift opened without staff engaging leg actuator. Further observation showed the legs opened a second time during the transfer without staff engaging the leg actuator. Observation of the leg actuator showed it did not lock into place when moved between open and closed and appeared to be damaged as the leg actuator moved freely and did not lock into place. 2. Observation on 8/2/18 at 10:51 AM showed the lift remained in use and staff used the lift to transfer resident #21. 3. Interview with the maintenance director on 8/2/18 at 10:51 AM revealed he was not aware the lift was broken and staff were to notify him if there were any problems so the lift could be taken out of use to be repaired. Further interview confirmed the lift was damaged and was not safe to use. 4. Interview with the administrator on 8/2/18 at 1:41 PM revealed the facility had 2 residents that required to be transferred using the damaged lift. 5. Review of the "Invacare Reliant 450" user manual dated 2013 showed "...8 Transferring the Patient...The legs of the patient lift must be in the maximum open position for optimum stability and safety..."	F 908	repair during transfers. 3. All residents are at risk that require the use of a full body lift, those residents will be transferred with a full body lift in good repair. 4. The NHA or designee will educate nursing staff the importance of notifying maintenance immediately when noticing any patient care equipment not operating in a safe condition and or not in good repair. 5. Maintenance or designee will do add to their matrix book to do monthly safety checks indefinitely. The results of the monthly checks will be brought to QAPI for three months or until resolved.	