STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535051	A. BUILDING _____ B. WING _____	C 05/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD THERMOPOLIS, WY 82443

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys on 5/19/19 through 5/22/19. Also reviewed in the course of the survey was complaint intake WY00002834. The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living CNA- Certified Nurse Aide DON- Director of Nursing LPN- Licensed Practical Nurse MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 576 SS=E	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and	F 576		7/6/19

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

Electronically Signed | 06/14/2019

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F 576	Continued From page 1 the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on resident group interview and staff interview, the facility failed to ensure a regular Saturday delivery of mail to the residents. The census was 39. The findings were: During the Resident Council Meeting on 05/21/19 10:31 AM three of the nine residents present stated they did not receive mail on a regular basis and could not recall getting any on Saturdays. In an interview with the business office manager on 5/21/19 at 2:10 PM it was acknowledged that the mail delivery was to a box at the post office. Pickup was done by an activity staff member, then the mail was sorted and delivered to the	F 576	1. Current and identified residents are receiving regular Saturday delivery of mail. 2. Current residents have the potential to be affected. 3. Activity/Weekend Manager staff educated on regulation that all residents are to receive mail addressed to them and received by the facility on everyday including Saturdays. Designated staff member will be responsible for picking up mail from Post Office Box on Saturdays and delivery recorded on monitoring form. 4. Executive Director/designee will audit for compliance weekly x 4 weeks and	

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F 576	Continued From page 2 residents at the facility. She further stated Saturday mail pickup was sporadic and only one staff member did it.	F 576	monthly x 2 months. The ED/designee will report the tracking and trending of the initial and random audits to the monthly QAPI meeting for ninety days or until substantial compliance has been achieved or sustained as directed by the committee.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		7/6/19

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F 584	Continued From page 3 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to ensure a clean and comfortable environment related to walls and floors in 3 of 5 hallways/resident areas (the main long hall, the memory care unit, the dining room hallway). The findings were: 1. Observation on 5/21/19 at 8:48 AM showed the following damaged areas that required paint and maintenance repairs off the long hallway and the hallway leading into the dining room: a. The floors at the entrance of the physical therapy room (room 4) had frayed and pealing red tape across the threshold. The tape was worn with a noticeable build-up of grime. b. The floor at the entrance of room 10 was soiled and discolored. There was also chipped paint and damage to an area on the wall near the bathroom entrance. One damaged area measured 2 inch by 2 inch, another measured 4 inch by 2 inch. c. The tiles on the floor leading into the bathroom of room 1 were broken discolored and had blackish brown build-up. d. Approximately 50 % of the visible floor in room 36 was discolored and looked unclean. In	F 584	1. Facility will ensure that residents are provided a warm, home-like environment. Tape at the threshold will be removed and area thoroughly cleansed at the entrance of the Therapy Gym (Room #4) before threshold is replaced without the use of tape. Room #10's flooring will be completely stripped and refinished. Damaged areas to the bathroom entrance of Room #10 will be repaired. Floor tile leading into the bathroom of Room #1 will be replaced. Flooring in Room #36 will be completely stripped and refinished as well as areas of damage to the bathroom door repaired. Door jambs leading into the kitchen and dish wash room will be scraped and fully repainted. The desk in the Memory Care Unit will be replaced. Areas of wall damage in the Memory Care Unit TV lounge will be fully repaired. Flooring in Rooms #23 and 25 will be completely stripped and refinished. Area of paint damage in the bathroom of Room #23 will be repaired. Areas of damage at the base of the countertop area where residents dine in the Memory Care Unit	

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F 584	Continued From page 4 addition, the bathroom door had scrapped and chipped paint on the lower half. e. In the hallway leading to the dining room, there was chipped and marred paint on the door jambs leading into kitchen and dish room. 2. Observation on 5/21/19 at 12:20 PM showed the following areas in need of repair in the memory care unit: a. The desk in the main area had 2 broken drawers and chipped paint on these drawers and the base of the desk. b. In the television lounge area there were three 1 inch by 1 inch areas of chipped paint on the green wall. In addition, there was an area of damaged wall near an interior door that measured 28 inches by 11 inches. c. The floors in resident rooms 23 and 25 were in need of cleaning, and the tiles were discolored. In addition, there was an area of chipped paint in the bathroom of room 23 above the sink that measured 4 inches by 5 inches. d. The counter used by some residents during the meal service had damaged areas on the base where the wood was separated and the paint was chipped. e. The wall below the activity bulletin board had areas of chipped paint in an area 5 feet long . 3. Interview on 5/21/19 at 3:18 PM with the administrator revealed the floors in the building were in the process of being cleaned. He personally was stripping and waxing the floors and had completed some of the project in the hallways and the main dining room. The plan included the floors in the resident rooms; however, there was no certain timeframe due to lack of personnel to work on the project. He stated resident rooms including #36 had not been	F 584	will be fully repaired. Areas of chipped paint damage under the Activity bulletin board in the MCU will be fully repaired. The facility has developed a sequential plan to 1) go room to room, refinishing floors, 2) replacing blinds and furniture, as well as 3) establishing a two tone universal color scheme for the rooms and halls. This would also include replacing the cabinetry in the MCU as well as kitchen, and oven replacement in the kitchen. 2. Current residents have the potential to be affected. Center-wide audit completed by ED with plan in progress. 3. Staff educated on the importance/significance of providing residents a warm, home-like environment. Interdisciplinary Team will make daily rounds to ensure substantial progress is being made toward ensuring warm, homelike environment and immediately record and address any outliers. 4. ED/designee will audit for compliance weekly x 4 weeks and monthly x 2 months. The ED/designee will report the tracking and trending of the initial and random audits to the monthly QAPI meeting for ninety days or until substantial compliance has been achieved or sustained as directed by the committee.	

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F 584	Continued From page 5 done, and some were unsightly with ground-in dirt. He further stated they were working on securing funding to make improvements, including the painting and damage repairs.	F 584		
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 medical record review, and staff interview, the facility failed to ensure a significant change of condition MDS assessment was completed for 1 of 2 sample residents (#42) with a change in conditions. The findings were: Review of the 10/2/18 annual MDS assessment showed resident #42 required limited assistance with 1 person physical assist for transfer and locomotion off the unit, and required supervision with 1 person physical assist for eating, walking in the room and the corridor, and locomotion on the unit. The following concerns were identified: a. Review of the 2/2/19 quarterly MDS assessment showed the resident had declined in	F 637	1. Resident #42 has passed away. 2. Current residents have the potential to be affected. Director of Nursing /designee conducted an audit going back 6 months to ensure that new Comprehensive Assessments were initiated for all residents with a significant change. 3. Director of Nursing, Minimum Data Set Coordinator, Social Service Director and Licensed Nurse staff educated on what a significant change is and the proper completion of a Comprehensive Assessment. Resident records will be reviewed in Daily Clinical Meeting to ensure Comprehensive Assessments have been/are initiated within 14 days of	7/6/19

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F 637	Continued From page 6 ADLs including transfer, walking both in room and corridor, and eating. All of these areas now required extensive assistance with 1 person physical assist. b. Review of the 2/9/19 nursing note timed at 8:24 AM showed "Resident continues on observation charting related to fall without injury and decreased appetite with generalized weakness ...." c. Review of the 2/15/19 nutrition/dietary note timed at 2:25 PM showed "Resident has had a 10% weight loss in last 180 days...Has declined in condition over the last 180 days [s/he] has had multiple UTI's and refuse to drink. [S/he] is placed at the assist table for meals - refused supplements and eating most days..." d. Review of the 2/26/19 nurse's note timed at 12:16 AM showed "Resident continues with significant functional decline. Refused medications and food. Takes sips of water but refuse more. Calls out for help but can't communicate needs." e. Review of the medical record failed to show a significant change MDS assessment was completed. f. Interview with the DON on 05/22/19 at 11:45 AM revealed she had oversight of the change of condition process, and a significant change MDS assessment should have been done in this instance.	F 637	any significant change for any resident. 4. DNS/designee will audit for compliance weekly x 4 weeks and monthly x 2 months. The DNS/designee will report the tracking and trending of the initial and random audits to the monthly QAPI meeting for ninety days or until substantial compliance has been achieved or sustained as directed by the committee.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to	F 644		7/6/19

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F 644	Continued From page 7 avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, and staff interview, the facility failed to complete a Preadmission Screening and Resident Review (PASARR) as required for 1 of 3 sample residents (#25) reviewed for PASARR needs. The findings were: Review of the medical record showed resident #25 was admitted on 6/13/18 with diagnoses which included seizure disorder, and metabolic encephalopathy. At that time there were no identified psychiatric or mental health diagnoses. Review of the PASARR level 1 showed it was completed on 6/13/18 and did not indicate the need to complete the PASARR level 2 process. The following concerns were identified: a. Review of the annual MDS assessment dated 4/30/19 showed a diagnosis of psychotic disorder other than schizophrenia had been added. b. Interview on 5/21/19 at 10:45 AM with the social services director revealed the diagnosis on the annual MDS assessment was new, and	F 644	1. Resident #25 PASARR has been updated. 2. Current residents have the potential to be affected. DNS/designee completed going back 6 months for new diagnoses that trigger for a PASARRII and said evaluations initiated immediately. 3. MDS, SSD and LN staff educated on the requirement that all residents who receive a new diagnosis which triggers for a PASARRII have said evaluation initiated immediately. Resident records will be reviewed in Daily Clinical meeting for any changes in diagnosis that would trigger a PASARRII evaluation and verification that evaluation has been initiated. Facility has implemented monitoring system to review diagnoses after every physician visit to ensure any diagnosis which triggers for a PASARRII has evaluation initiated immediately. 4. DNS/designee will audit for compliance weekly x 4 weeks and monthly x 2	

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F 644	Continued From page 8 related to this a PASARR level 2 was required. She then confirmed the PASARR 2 had not been completed.	F 644	months. The DNS/designee will report the tracking and trending of the initial and random audits to the monthly QAPI meeting for ninety days or until substantial compliance has been achieved or sustained as directed by the committee.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		7/6/19

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F 656	Continued From page 9 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, medical record review and staff interview, the facility failed to develop a comprehensive person-centered plan of care for 5 of 12 residents (#23, #31, #36, #39, #42). The findings were: 1. Medical record review showed resident #39 was admitted on 10/18/19 with diagnoses which included diabetes mellitus, rheumatoid arthritis, and cerebral infarction with hemiparesis to right side. Review of the quarterly MDS assessment dated 5/12/19 showed the resident had a BIMS of 15 (cognitively intact), required supervision and assist of one staff member for dressing, transfers and ambulation, and had range of motion limitations on one side for upper and lower extremity. The following concerns were identified: a. Observation on 5/19/19 at 4:00 PM showed the resident entered the building from outdoors in a wheelchair. Continued observation on 5/19/19 at 6:00 PM showed the resident riding a stationary bike. b. Interview on 5/20/19 at 9:57 AM with the resident revealed s/he did not participate in therapy, and performed exercises independently. c. Review of the care plan failed to show	F 656	1. Facility has developed a comprehensive person-centered care plan for residents #23, 31, 36, 39 and 42 consistent with resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Resident #39's Care Plan adjusted to reflect interventions related to exercise and range of motion exercises. Resident #23's care plan was adjusted to reflect non-medication interventions for pain. Resident #31's Care Plan was adjusted to reflect individual activity preferences. Resident #31's Care Plan was also adjusted to reflect interventions to prevent urinary incontinence and to keep the resident clean and dry. Resident #36's Care Plan was adjusted to reflect activity needs and approaches. Resident #42's Care Plan was adjusted to reflect changes in care needs related to significant weight loss and ADL decline. 2. Current residents have the potential to	

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F 656	Continued From page 10 interventions related to exercise and range of motion limitations. d. Interview on 5/21/19 at 3:56 PM with the DON revealed the resident did not have a formal restorative program. She stated the resident rode the stationary bike for at least 20 minutes a day. She stated the resident walked in the hallway with staff at night using a walker. She also stated the resident went outside and used a small rake to rake around the yard. She confirmed staff did not document these activities and the interventions were not documented on the care plan. 2. Review of the 4/23/19 significant change MDS assessment showed resident #23 had almost constant pain, with a pain intensity of 8/10, which limited his/her activities of daily living. The assessment showed scheduled pain medication and non-medication interventions were used. The care area assessment related to pain showed the resident's pain was located to bilateral hips and low back. The following concerns were identified: a. Review of the care plan revised on 5/5/19 showed it was not developed to include non-medication interventions. b. Interview with the resident on 5/20/19 at 9:49 AM revealed s/he sat in the wheelchair with a stool to prop his/her feet on and it was not always comfortable. The resident had a recliner in the room but stated it was too small and s/he didn't fit in it. c. Interview with the DON on 5/21/19 at 5:08 PM revealed the resident would benefit from non-medication interventions for pain and the care plan should be developed. She stated a couple of weeks ago she asked him/her about trying another recliner and at that time the resident had declined.	F 656	be affected. DNS/designee audited resident Care Plans to ensure that plans are fully updated, developed individually, and revised appropriately. 3. Social Service Director, Activity Director, MDS Coordinator, Dietary Manager and LN staff educated on the requirement that Care Plans be fully developed and revised appropriately. Resident Care Plans will be reviewed in weekly High Risk Meeting to ensure that Care Plans are fully updated, developed individually, and revised appropriately. 4. DNS/designee will audit for compliance weekly x 4 weeks and monthly x 2 months. The DNS/designee will report the tracking and trending of the initial and random audits to the monthly QAPI meeting for ninety days or until substantial compliance has been achieved or sustained as directed by the committee.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD THERMOPOLIS, WY 82443

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F 656	Continued From page 11	F 656		

3. Review of the 3/15/19 admission MDS assessment showed resident #31 had identified activity preferences that were coded as very and somewhat important to him/her. The 3/18/19 initial activity evaluation showed specific areas of current interest the resident had including pets/animals, religious activities, games, music, movies and gardening. The following concerns were identified:

a. Review of the care plan revised on 3/25/19 showed it lacked individual activity preferences. The interventions showed staff were to encourage the resident to participate in "activities of choice and facilitate attendance as required."

b. Interview with the DON on 5/22/19 at 9:15 AM verified the care plan required development.

4. Review of the 5/15/19 quarterly MDS assessment showed resident #31 did not have a catheter and was frequently incontinent of urine. Observation on 5/19/19 at 4:25 PM showed the resident was in his/her wheelchair in the common area and had a noticeable odor of urine. The resident was confused and stated s/he did not need any assistance or help with anything. The following concerns were identified:

a. Review of the care plan revised on 5/16/19 showed the resident was incontinent and required extensive assistance, there were no additional details to show a plan or interventions to help prevent the urinary incontinence, or keep the resident clean and dry.

b. Interview with the DON on 5/22/19 at 9:15 AM verified the resident had a urinary catheter which had been discontinued and the care plan required more development to include interventions.

5. Review of the 4/16/19 admission MDS

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F 656	Continued From page 12 assessment showed resident #36 was interviewed for activity preferences and all were somewhat important except going outside in good weather, which was very important. In addition, the 4/9/19 initial activity evaluation showed the resident had current interests some of which were animals/pets, bingo, bowling, music, movies, cooking/baking, and outdoor living. The following concerns were identified: a. Review of the care plan showed there were no activity needs or approaches identified. b. Interview with the activity director on 5/22/19 at 9:16 AM revealed the care plan had not been developed related to activities; it had been overlooked. 6. Review of the nurse's notes from 2/9/19 to 2/28/19 showed resident #42 had a significant change in condition including ADL decline and significant weight loss. Review of the 10/2/18 annual MDS assessment and the 2/2/19 quarterly MDS assessment showed the resident had significant declines in ADLs. The following concerns were identified: a. Review of the care plan showed it was last revised/update on 4/28/18 and did not address the changes in care needs. b. Interview with the DON on 05/22/19 at 11:45 AM revealed she had oversight of the change of condition process, and the change in care plans, and that they should have been done in this instance.	F 656		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan	F 679		7/6/19

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F 679	Continued From page 13 and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure activity needs were met for 2 of 2 sample residents (#31, #36) reviewed for activities. The findings were: 1. Review of the 3/15/19 admission MDS assessment showed resident #31 had identified activity preferences that were coded as very and somewhat important to him/her. The 3/18/19 initial activity evaluation showed specific areas of current interest the resident had including pets/animals, religious activities, games, music, movies and gardening. The following concerns were identified: a. Review of the care plan revised on 3/25/19 showed it lacked individual activity preferences. The interventions showed staff were to encourage the resident to "participate in activities of choice and facilitate attendance as required." b. Review of the April 2019 activity participation log showed 12 days from 4/10/19 to 4/21/19 when no activity participation was documented. c. Review of the May 2019 activity participation log showed 4 days from 5/16/19 to 5/19/19 when no activity participation was documented, on 5/20/19 the log showed the resident passively participated in 2 group	F 679	1. Residents #31 and 36 had the Activity portion of their MDSs fully developed and revised immediately, including one on one activities that cater to the individual interests of both residents. 2. Current residents have the potential to be affected. Facility audited resident Care Plans to ensure the Activity portion of each resident's MDS was fully developed and revised. One on one activities were immediately initiated for those residents found not to prefer group activities. 3. Activities Coordinator and staff educated on the requirement that the Activity portion of the MDS be fully developed and revised appropriately; also the requirement that one on one activities be provided for those residents who prefer not to participate in group activities. Resident records will be reviewed in Weekly High Risk Meeting to ensure one on one activities are being provided for residents who do not prefer to engage in group activities as well as ensuring activity portion of MDSs are fully developed and revised appropriately for every resident. 4. ED/designee will audit for compliance weekly x 4 weeks and monthly x 2 months. The ED/designee will report the	

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F 679	Continued From page 14 activities. d. Interview with the activity director on 5/22/19 at 9:16 AM revealed it was difficult to get the resident to participate in the activities. Most participation was passive. She stated the resident was adjusting and enjoyed when family came to visit. 2. Review of the 4/16/19 admission MDS assessment showed resident #36 was interviewed for activity preferences and all were somewhat important except going outside in good weather, which was very important. In addition, the 4/9/19 initial activity evaluation showed the resident had current interests, some of which were animals/pets, bingo, bowling, music, movies, cooking/baking, and outdoor living. The following concerns were identified: a. Review of the care plan showed there were no activity needs or approaches identified. b. Periodic observations on 5/20/19 at 9:44 AM, 11:20 AM and 3:28 PM showed the resident was in bed asleep and not engaged in activities. c. Review of the April 2019 activity participation log showed no documented activity participation for 10 days from 4/11/9 to 4/21/19. d. Review of the May 2019 activity participation log showed 6 days from 5/14/19 to 5/19/19 with no documented activities. On 5/20/19 the resident was documented as passively participating in 4 activities. e. Interview with the activity director on 5/22/19 at 9:16 AM revealed a care plan had not been developed related to activities; it had been overlooked.	F 679	tracking and trending of the initial and random audits to the monthly QAPI meeting for ninety days or until substantial compliance has been achieved or sustained as directed by the committee.	
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3)	F 727		7/6/19

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F 727	Continued From page 15 §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of staffing schedules, posted daily nurse staffing information, and staff interviews, the facility failed to ensure the services of an RN were utilized for 8 hours a day 7 days a week for 6 of 51 days reviewed (4/8/19, 4/15/19, 5/3/19, 5/4/19, 5/5/19, 5/18/19). The facility census was 39. The findings were: Review of the April and May 2019 schedules and posted daily nurse staffing information revealed there were 4 days when an RN was not scheduled (4/08, 4/15, 5/03, 5/18). Also there were 2 days when an RN was scheduled for only 4 hours each day (5/04, 5/05). Interview with staff LPN on 05/21/19 04:45 PM revealed that there were many times they worked without an RN available. During the interview with the DON on 5/22/19 at 11:45 AM it was acknowledged that every attempt was made to meet the 8 hour per day requirement, but occasionally due to call-ins or	F 727	1. Facility will ensure that RN coverage is provided 8 consecutive hours per day, 7 days per week. 2. Current residents have the potential to be affected. Initial audit completed by ED to identify other days that did not have RN coverage going back 90 days. 3. LN leadership team educated on the requirement that the facility is to ensure RN coverage 8 consecutive hours per day, 7 days per week and that when any team member works as a floor nurse they are to submit a TAF recording those hours worked to the BOM the same day. Time Adjustment Forms will be submitted to the Business Office Manager by any member of the RN leadership team on the same day they work as a floor nurse (at least 8 consecutive hours) and not in their intended capacity to ensure that the requirement for RN coverage is met and recorded. Staffing will be reviewed during Daily Stand Up Meeting to ensure RN	

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F 727	Continued From page 16 staff vacations, an RN was not available. During those times LPN staffing or short shift RN staffing was utilized.	F 727	coverage for the day in compliant and properly documented. 4. ED/designee will audit for compliance weekly x 4 weeks and monthly x 2 months. The ED/designee will report the tracking and trending of the initial and random audits to the monthly QAPI meeting for ninety days or until substantial compliance has been achieved or sustained as directed by the committee.	
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 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 and staff interview the facility failed to ensure food was stored with proper dates/labels in 1 of 3 refrigerators (the walk-in refrigerator). In addition, the facility failed	F 812	1. Facility will ensure that all stored food items are labeled appropriately with expiration dates. Facility will also ensure the kitchen is in good repair and that all	7/6/19

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F 812	Continued From page 17 to ensure effective sanitation related to surfaces and equipment conditions in the kitchen and dish room. The findings were: 1. Observation on 5/19/19 at 3:40 PM showed there were items in the walk-in-refrigerator without dates including cooked chicken in a bag and sliced ham. There was also a plastic bag labeled "grilled chicken" with dates of "5/13/19 and 5/17/19." Interview with the certified dietary manager (CDM) on 5/21/19 at 11:20 AM confirmed the food should be labeled with an expiration date, and discarded by that date. 2. Observation on 5/21/19 at 10:55 AM showed the following equipment and surface condition issues: a. The 2 ovens in the kitchen had broken doors. One door had a temporary fix to secure the door shut, and the other was loose and did not close all the way. Both ovens were in use. b. The condition of the tile floor in the kitchen was uncleanable. The majority of tiles were chipped and cracked and the areas around the base of the equipment and the edges of the walls were soiled with grime and built-up. c. The area behind the 3-compartment sink was uncleanable. There was a wooden board used to cover part of the wall under the sinks which had an uncleanable painted surface. In addition, the wall on the upper part had areas that were unsealed and cracked. There were also wooden blocks used under the footing of the sinks which were soiled and uncleanable. d. The wooden cabinets and drawers were damaged and had paint peeling off, creating an uncleanable condition. There were 9 drawers/cabinet doors with broken latches or runners.	F 812	surfaces are sanitizable. On 5/22/19 all outdated or unlabeled food items were immediately disposed of. Facility will replace oven with broken handles. Tiles in disrepair were be replaced; the entire kitchen floor was stripped and finished to ensure a clean, sanitizeable surface. All areas cited as unsanitizeable under the double sink was repaired to ensure a clean, sanitizeable surface. Cabinets in the kitchen will be replaced to ensure cabinet surfaces are clean and sanitizeable. Tape around the hand washing sink was removed to ensure a sanitizeable surface. Wall on the clean side of the dish room was repaired and wooden board removed to ensure a clean, sanitizeable surface. The facility has developed a sequential plan to 1) repair/replace cracked floor tile, 2) replace oven, and 3) replace cabinetry. All other issues that could be addressed immediately were. 2. Current residents have the potential to be affected. CDM/designee immediately audited kitchen storage for any food stored without proper labeling and were immediately disposed of. 3. Dietary staff educated on the requirement that the kitchen be in good repair, all surfaces must be sanitizeable, and that all food stared must be appropriately labeled with expiration dates and that food that has expired must be immediately disposed of. IDT will do daily rounds to ensure substantial progress being made in ensuring all surfaces in kitchen are sanitizable with outliers being recorded and immediately addressed.	

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F 812	Continued From page 18 e. The counter top located by the hand washing sink was damaged and had been covered with tape which was frayed and peeling. The condition created an uncleanable surface. f. The wall on the clean side of the dish room which opened into the kitchen was damaged. The wooden board attached to the wall had chipped paint that could not be effectively cleaned. 3. Interview with the CDM on 5/21/19 at 11:20 AM revealed these condition issues were ongoing and fixes had been discussed; however, there was no known schedule or timeline for repairs at that time.	F 812	Dietary staff will audit stored food inventory for proper labeling each shift (2x daily). 4. ED/designee will audit for compliance weekly x 4 weeks and monthly x 2 months. The ED/designee will report the tracking and trending of the initial and random audits to the monthly QAPI meeting for ninety days or until substantial compliance has been achieved or sustained as directed by the committee.	
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, 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	F 880		7/6/19

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F 880	Continued From page 19 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. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 20 §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, resident interview, staff interview, policy and procedure review, and review of professional standards, the facility failed to implement infection control processes to prevent infection transmission in 3 random observations. The findings were: 1. Observation on 5/20/19 at 11:41 AM showed the DON performing a dressing change on the right heel of resident #14. The DON donned gloves, removed the old dressing and cleansed the wound. The DON touched the wound, then grabbed her glasses from her head and put them on. The DON removed the gloves and touched the clean dressing supplies without performing hand hygiene. The DON put another pair of gloves on and placed a clean dressing and wound VAC (vacuum assisted closure) device on the right heel. The following concerns were identified: a. Interview with the DON on 5/22/19 at 10:22 AM revealed hand hygiene should be performed after dressing removal and before putting a clean dressing on a wound. b. Review of the "Handwashing/Hand Hygiene" policy updated 3/18 showed "7. Use an alcohol-based hand rub ...for the following situations ...g. before handling clean or soiled dressings ....k. after handling used dressings ...m. after removing gloves ..." 2. Interview with resident #6 on 5/20/19 at 10:53 AM revealed s/he was being treated for	F 880	1. The Facility will ensure that infection control processes to prevent infection transmission are being observed. Facility will ensure hand hygiene is performed after dressing removal and before putting a clean dressing on a wound. Facility will ensure that all nebulizer equipment (including machine) is adequately sanitized before and after treatments and placed in a bag. Facility will ensure appropriate medication injection process is in practice related to deficiency. 2. Current residents have the potential to be affected. DNS/designee performed audit to ensure all nebulizer equipment and sanitary injection process. MDS performed initial audit for dressing change protocol. 3. Staff educated on proper handwashing/sanitizing protocol for wound care and the requirement that nebulizer equipment be sanitized and stored appropriately. DNS/designee will conduct daily observation audits to ensure proper handwashing/sanitizing protocol being followed. 4. DNS/designee will audit for compliance weekly x 4 weeks and monthly x 2 months. The DNS/designee will report the tracking and trending of the initial and random audits to the monthly QAPI meeting for ninety days or until substantial compliance has been achieved or	

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F 880	Continued From page 21 pneumonia and had been receiving breathing treatments as needed every 6 hours for the past 2 weeks. Observation at that time showed the nebulizer (breathing treatment machine) was located on the table near the resident's recliner in his/her room. The tubing and mask were attached and droplets were visible inside the medication cup part of the tubing. Additional observation and interview with the resident on 5/21/19 at 10:23 AM revealed the resident had not seen staff clean or rinse the nebulizer machine after use. The tube, medication cup and mask were all attached and laying uncovered on her bedside table with visible droplets inside the equipment. The following concerns were identified: a. Review of the the facility policy and procedure titled "Medication Administration Quick Reference Guide" updated June 2017 showed "...19. Nebulizer treatments a. Clean equipment and place in bag after use." b. Interview on 5/22/19 at 11:04 AM with the DON revealed the nebulizer machine should be cleaned after each use. 3. Observation on 5/21/19 at 9:20 AM showed LPN #1 opened a new vial of novolog insulin. She did not wipe the rubber septum with an alcohol wipe prior to inserting a syringe. Interview with the DON on 5/22/19 at 10:22 AM revealed she thought if the vial was not opened it was sterile. According to the APIC Position Paper: "Safe Injection, Infusion, and Medication Vial Practices in Healthcare (2016): "...Disinfect the rubber septum on all vials prior to each entry, even after initially removing the cap of a new, unused vial..."	F 880	sustained as directed by the committee.	