STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535045	A. BUILDING _____ B. WING _____	07/11/2019

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 7/8/19 to 7/11/19. The following common abbreviations are used throughout this document. ADL: Activities of Daily Living BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing MDS: Minimum Data Set mg: Milligram RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make	F 561		8/25/19

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

Electronically Signed | 08/02/2019

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F 561	Continued From page 1 choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, medical record review, and review of facility bathing schedules, the facility failed to honor resident preferences for 1 of 1 sample resident (#45) related to bathing. The findings were: Interview with resident #45 on 7/9/19 at 10:11 AM revealed residents were not able to choose bath days. The resident was scheduled for showers on Thursdays and Sundays and said the bathing schedule interfered with participation in church services. Further interview revealed the resident had to get up as early as 5:30 AM at times to receive a bath. Review of the admission MDS assessment dated 11/6/18 showed the resident felt it was "very important" to choose his/her bath, shower, bed bath, or sponge bath and attend religious services. Review of the facility's bathing schedule showed the resident was to receive a bath during the day shift on Thursday and Sunday. Further review showed the facility provided showers on the evening shift 7 days per week. Review of the resident's care plan initiated on 11/20/18 showed "I have a self care deficit r/t	F 561	1. F561 2. All residents will have the right to choose activities, schedules, health care and providers of health care services consistent with his or her interests, assessments, and plan of care. Resident #45's care plan will be updated to reflect her bathing preferences. 3. All residents have the ability to be affected by their choices not being honored. All Residents will have the right to choose activities, schedules, health care and providers of health care services consistent with his or her interests, assessments, and plan of care. Care Center Nursing Director or designee will review the bathing preferences of all of the residents by August 25, 2019. Care Center Nursing Director or designee will update care plans and bathing schedule to match preferences if necessary. 4. All staff will be reeducated on the	

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F 561	Continued From page 2 [related to] impaired cognition and chronic pain from my osteoarthitis." Interventions included "Bathing: I need help with my bath twice per week." There was no evidence the resident's preferences were identified on the care plan. Review of the resident's admission document dated 10/29/18 showed on the "Resident's Choices and Preferences" document the resident preferred bathing in the afternoon or evening. Interview with the DON on 7/10/19 at 2:22 PM revealed residents were asked about bathing preferences at the time of admission and the facility placed them on the schedule based on the other facility residents' bathing schedules.	F 561	resident's right to choose. A mandatory all staff meeting will be held on August 14, 2019 and education will include the Residents' right to choose activities, schedules, health care and providers of health care services consistent with his or her interests, assessments, and plan of care. Administrator, Director of Nursing, Interdisciplinary team will meet no later than August 25, 2019 and will review policies on care plans and revise if necessary to ensure Resident choice is being met and care planned appropriately. 5. The Care Center Nursing Director or designee will perform monthly random audits to ensure resident's choices are being honored and the resident's care plan is being followed. The audit data will be aggregated monthly and reported quarterly to the Administrator, Medical Director, QAPI Steering Committee, and Quality Council. The QAPI Steering Committee will ensure overall compliance.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or	F 578		8/25/19

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F 578	Continued From page 3 inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure residents' right to formulate an advanced directive for 3 of 21 sample residents (#12, #13, #47). The findings were: 1. Review of the medical record for resident #12	F 578	1. All residents will have the right to request, refuse, and /or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Residents' #12, #13, #47 medical records have been updated to reflect the	

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F 578	Continued From page 4 showed the resident was listed as do not resuscitate (DNR). The following concerns were identified: a. Review of a physician note, which was undated and untimed, provided by the facility on 7/10/19 at 8:38 AM showed the resident was marked as DNR with an "advanced directive on file." b. Review of the medical record showed the facility had no document signed by the resident or resident's representative to identify the resident's code status election. 2. Review of the medical record for resident #13 showed the resident was listed as DNR. The following concerns were identified: a. Review of a physician note, which was undated and untimed, provided by the facility on 7/10/19 at 8:38 AM showed the resident was marked as DNR with an "advanced directive on file." b. Review of the medical record showed the facility had no document signed by the resident or resident's representative to identify the resident's code status election. 3. Review of the medical record for resident #47 showed the resident was listed as DNR. The following concerns were identified: a. Review of a physician note, which was undated and untimed, provided by the facility on 7/10/19 at 8:38 AM showed the resident was marked as DNR with an "advanced directive on file." b. Review of the medical record showed the facility had no document signed by the resident or resident's representative to identify the resident's code status election.	F 578	resident's choice regarding their advanced directives. 2. All residents have the ability to affected by their choice to formulate advanced directives not being honored. All residents will have the right to formulate an advanced directive. All the residents' charts will be reviewed and updated if necessary for code status election by the Care Center Nursing Director or designee by August 25, 2019. 3. Administrator, Nursing Director, Social Service Worker will meet no later than August 25, 2019 to review Admission policies and procedures. Procedure will include a document that will identify resident's wishes regarding advanced directives and a code status election. 4. The Care Center Nursing Director or designee will perform monthly random audits to ensure resident's choices have been identified regarding advanced directives and code status has been elected. The Care Center Nursing Director or Designee will also audit if the resident's advanced directives are being followed by the facility. The audit data will be aggregated monthly and reported quarterly to the Administrator, Medical Director, QAPI Steering Committee, and Quality Council. The QAPI Steering Committee will ensure overall compliance.	

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F 578	Continued From page 5 4. Interview with unit ward clerk #1 on 7/10/19 at 1:23 PM revealed some residents admit with documents indicating their advanced directives; however, often times residents admit with a transfer document signed by the physician which indicates code status. Further interview revealed the facility did not have signed elections for residents.	F 578		
F 584 SS=D	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	F 584		8/25/19

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F 584	Continued From page 6 resident room, as specified in §483.90 (e)(2)(iv); §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 furniture utilized by residents was clean and in good repair in 1 of 3 units (South). The findings were: 1. Observation of the South common area on 7/10/19 at 1:10 PM showed the following concerns. a. A brown vinyl recliner chair located on the south side of the common room had an area on the right arm rest which measured 7 inches by 5.5 inches; an area on the left arm rest which measured 8 inches by 6 inches; and an area on the headrest which measured 5.5 inches by 4 inches with the outer vinyl missing, and the underlying padding exposed. These areas created a surface that could not be effectively cleaned. b. A brown vinyl recliner chair located on the north side of the common room had an area on the right arm rest which measured 6.5 inches by 7 inches and an area on the left arm rest which measured 8 inches by 5.5 inches with the outer vinyl missing, and the underlying padding exposed. In addition, the headrest had 3 cracks	F 584	1. All residents have the right to a safe, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safety. The facility will provide a safe, clean, comfortable, and homelike environment allowing the resident to use his or her personal belongings to the extent possible. The furniture that was unable to be cleaned in the south unit has been removed and disposed of. The south unit received new furniture to replace the old furniture. 2. All residents have the ability to be affected by furniture that cannot be effectively cleaned. All residents have the right to a safe, comfortable, and homelike environment. 3. Administrator, Nursing Director, and Unit Primary nurses will meet no later than August 25, 2019 to determine a procedure for monitoring the furniture in each unit. Furniture that cannot be cleaned will be replaced. 5. The Care Center Nursing Director or	

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F 584	Continued From page 7 measuring 3 to 5 inches long with the vinyl peeling away from the edges. These areas created a surface that could not be effectively cleaned. 2. Interview with the infection prevention nurse on 7/10/19 at 3:26 PM confirmed the recliners could not be effectively cleaned.	F 584	designee will perform an audit on each piece of furniture in the unit to determine if furniture if the furniture meets compliance. The Care Center Nursing Director or designee will perform monthly random audits after that. The audit data will be aggregated monthly and reported quarterly to the Administrator, Medical Director, QAPI Steering Committee, and Quality Council. The QAPI Steering Committee will ensure overall compliance.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure MDS assessment information was an accurate reflection of resident status for 2 of 24 sample residents (#20, #47). The findings were: 1. Review of the PASARR (pre-admission screening and resident review) Level II determination completed on 10/20/15 showed resident #20 met the state definition of having serious mental illness. The following concerns were identified: a. Review of the annual MDS assessment dated 10/9/18 and the significant change MDS assessment dated 4/10/19 showed section A1500 [Has the resident been evaluated by Level II PASARR and determined to have a serious mental illness and/or mental retardation or a related condition?] was coded as 0 [No].	F 641	641 1. All residents will have their assessment accurately reflect their status. The MDS assessments for residents #20 and #47 will be modified and resubmitted by August 09, 2019. 2. All residents have the ability to be affected by their assessment not accurately reflecting their status. 3. Administrator, Nursing Director, data entry clerk, and all members of the Interdisciplinary team will have a meeting no later than August 25, 2019 to reevaluate MDS coding and be reeducated on the MDS process regarding residents that have previously flagged for a PASARR level II. 4. The Care Center Nursing Director or designee will compile a list of residents	8/25/19

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F 641	Continued From page 8 2. Review of the PASARR Level II determination completed on 8/18/14 showed resident #47 met the state definition of having serious mental illness. The following concerns were identified: a. Review of the annual MDS assessment dated 8/14/18 showed section A1500 [Has the resident been evaluated by Level II PASARR and determined to have a serious mental illness and/or mental retardation or a related condition?] was coded as 0 [No]. 3. Interview on 7/11/19 at 10:09 AM with the DON revealed he was unsure why the PASARR II evaluations were not coded as being complete on the MDS assessments.	F 641	who previously flagged for PASARR level II. The Care Center Nursing Director or designee will audit monthly MDS coding compliance for PASARR level II. The audit data will be aggregated monthly and reported quarterly to the Administrator, Medical Director, QAPI Steering Committee, and Quality Council. The QAPI Steering Committee will ensure overall compliance.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		8/25/19

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F 657	Continued From page 9 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure the comprehensive care plan was revised as needed to reflect the resident's current needs for 3 of 21 sample residents (#21, #58, #81). The findings were: 1. Review of the 4/11/19 admission MDS assessment showed resident #21 was admitted to the facility on 4/5/19 and had diagnoses which included Alzheimer's disease. Further review showed the resident had a BIMS score of 3/15 (cognitively impaired), wandered daily, and exhibited no behaviors in the 7-day look-back period. The following concerns were identified: a. Observation on 7/8/19 at 5:17 PM showed the resident was sitting next to a resident of the opposite sex in the common room and was then redirected to another recliner by CNA #1. b. Review of a nurse's note dated 6/1/19 showed the resident was found in another resident's room with his/her genitals exposed. Further review showed "Redirected resident after heated conversation." c. Review of a nurse's note dated 6/3/19 showed the resident was placed on hourly behavior monitoring. d. Interview with RN #1 on 7/10/19 at 1:33 PM revealed staff had been monitoring the	F 657	1. All residents will have their comprehensive care plan revised as needed to reflect the current needs of the resident. Residents' #21 and #58 will have their care plan updated to reflect their current needs. Resident #81 care plan cannot be updated do to the fact the resident has expired. 2. All residents have the ability to affected by their care plans not being revised to reflect their current needs. All the residents care plans will be reviewed for accuracy. The Care Center Nursing Director or designee will select 5 residents weekly and review the residents care plan for accuracy until all the resident's care plans have been reviewed. The care plans will be updated to reflect the resident's current needs if necessary. 3. All staff will be reeducated about the requirement to revise the residents care plans to reflect the residents current need on August 14, 2019. The Nursing Director and Interdisciplinary team will review and if necessary revise care plan policy and procedure by August 25, 2019. 4. The Care Center Nursing Director or designee will conduct random monthly audits of the care plans to ensure that the	

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F 657	Continued From page 10 resident hourly since the first of June. Activities to keep the resident busy included doing "chores" such as sweeping and dusting and working outside in the courtyard. In addition, the resident would continually seek out the other resident and staff would attempt to separate them, however, it was difficult to keep them apart. e. Review of the care plan failed to show it had been revised to include measurable goals and interventions/approaches related to the resident's behaviors. f. Interview with the DON on 7/10/19 at 5:41 PM confirmed the care plan had not been revised. 2. Review of the quarterly MDS assessment dated 5/28/19 showed resident #58 had diagnoses which included diabetes mellitus, non-Alzheimer's dementia, and depression, and required supervision with setup help for eating. Review of the care plan last revised on 6/4/19 showed "I have potential for uncontrolled BG's [blood glucose] r/t [related to] DM2 [diabetes mellitus type 2] treated w/ [with] insulin and oral agents; I am allergic to grapefruit and niacin; I am at dehydration risk r/t poor fluid intakes, medications, dx [diagnosis], age" and interventions included " I will consume 80% of at least 2+ meals daily; I will feed myself w/cueing and supervision x 90 days I will drink 1100 cc fluids/day x 90 days..." The following concerns were identified: a. Observation on 7/8/19 at 6:23 PM showed the resident was at the dining room table with a plate of food in front of him/her. An unidentified staff member said the resident's name two times and the resident did not respond. The staff member did not provide any further verbal cues and did not attempt physical assistance with	F 657	care plans that have been revised are reflecting the residents current needs. If any care plans are found to be inaccurate with what the residents current needs are the care plans will be updated during the next care plan meeting. The audit data will be aggregated monthly and reported quarterly to the Administrator, Medical Director, QAPI Steering Committee, and Quality Council. The QAPI Steering Committee will ensure overall compliance.	

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F 657	Continued From page 11	F 657		

meals. The resident did not eat any of his/her meal.

b. Review of the care plan last revised on 6/4/19 showed there was no evidence of interventions for staff to offer an alternate meal, staff to provide physical assistance, or offer meal replacements.

c. Interview with the dietitian on 7/10/19 at 2:39 PM revealed the resident had stopped eating as much during meals due to his/her dementia progression and staff should attempt to provide verbal and physical assistance, offer alternative meals, and offer meal replacement shakes. Further, she confirmed the interventions should have been on the care plan; however, she expected the staff to attempt interventions for all residents who did not eat a meal.

3. Review of the 4/16/19 quarterly MDS assessment showed resident #81 was admitted to the facility on 10/30/14 and had diagnoses which included Alzheimer's disease and vascular dementia with behavioral disturbances. The resident required the extensive assistance of 1 person for all ADLs. The following concerns were identified:

a. Review of a nurse's note dated 5/22/19 showed the resident was found unresponsive at 4:15 PM and was transferred to the emergency department. The resident returned to the facility at 6 PM on comfort care.

b. Review of a physician's progress note dated 5/23/19 showed the resident had suffered a "significant stroke" on 5/22/19. All medications had been stopped except for morphine and atropine. Further review showed "Just comfort care at this point."

c. Review of nurses' notes starting on 5/23/19 showed the resident was repositioned every two

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F 657	Continued From page 12 hours, received oral care hourly, and was receiving atropine and morphine. The resident expired on 5/30/19. d. Review of the care plan failed to show revisions related to comfort care. e. Interview with the DON on 7/10/19 at 5:41 PM confirmed the care plan had not been revised.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure resident safety during 1 of 4 observations of mechanical lift transfers, which affected resident #12. The findings were: 1. Review of the annual MDS assessment dated 4/2/19 showed resident #12 had diagnoses which included arthritis and non-Alzheimer's dementia, and required extensive physical assistance of 1 person for bed mobility. Review of the care plan last revised on 4/23/19 showed "I have impaired mobility r/t a disability in my lower extremities and confusion" and interventions included "Transfer: I use an EZ lift with two staff assist." The following concerns were identified: a. Observation on 7/9/19 at 8:21 AM showed	F 689	1. All residents will receive adequate supervision and assistive devices to prevent accidents and the resident environment will remain free of accident hazards as much as possible. Staff will be reeducated about the proper use and function of assistive devices. The observation with the transfer that affected resident #12 cannot be fixed due to the fact it already has happened. Staff have been reeducated on resident #12's care plan and the residents need for assistance of 2 people during transfers. 2. All residents have the ability to be affected by the environment not being free from accident hazards and their care plan not being followed during cares. All	8/14/19

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F 689	Continued From page 13 CNA #2 placed a lift sling under the resident and then attached it to the mechanical lift. The CNA lifted the resident and transferred him/her via mechanical lift without the assistance of a second staff member. The CNA positioned the resident above the geri-chair and lowered him/her into the chair. b. Interview with the DON on 7/10/19 at 3:24 PM revealed there must be 2 staff members present for transfer with the mechanical lift if it was indicated on the care plan.	F 689	residents care plans will be followed. The facility will ensure the residents are safe during transfers by reeducated the staff, updating care plans, and auditing staff for lift transfer compliance. 3. Administrator and Nursing Director will review and update Safety and Mechanical Lift procedures. An all staff meeting will held on August 14, 2019 to reeducate the staff about our procedures regarding lifts and safety of our residents and also to verify transfer status through the residents care plan, and following the residents care plan. To ensure the residents are safe during transfers the restorative nurse tracks how each resident is transferred and updates it quarterly or as needed in the care plans. 4. The Care Center Nursing Director or designee will compile a list of each resident that uses a lift for transfers. The Care Center Nursing Director or designee will review each resident on the list's care plan to ensure, proper lift procedure is being followed. The Care Center Nursing Director or designee will monitor and conduct random monthly audits during transfers of residents that need the assistance of a mechanical lift. The Care Center Nursing Director or designee will also monitor and conduct random monthly audits of staff's compliance with residents care plans. The audit data will be aggregated monthly and reported quarterly to the Administrator, Medical Director, QAPI Steering Committee, and Quality Council. The QAPI Steering Committee will ensure overall compliance.	

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F 692	Continued From page 14	F 692		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, the facility failed to ensure residents received interventions to ensure proper nutrition during 1 of 3 meal observations for 1 sample resident (#58) with a history of weight loss. The findings were: 1. Review of the quarterly MDS assessment dated 5/28/19 showed resident #58 had diagnoses which included diabetes mellitus, non-Alzheimer's dementia, and depression, and required supervision with setup help for eating. Review of the care plan last revised on 6/4/19	F 692	1. The facility will ensure that the residents maintain an acceptable parameter of nutritional status, such as body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. Staff will be reeducated on the importance of offering additional verbal cues or physical assistance, offering alternative meals or meal replacement shakes. Resident #58's care plan has been reviewed by the	8/25/19

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F 692	Continued From page 15 showed "I have potential for uncontrolled BG's [blood glucose] r/t [related to] DM2 [diabetes mellitus type 2] treated w/ [with] insulin and oral agents; I am allergic to grapefruit and niacin; I am at dehydration risk r/t poor fluid intakes, medications, dx [diagnosis], age". Interventions included " I will consume 80% of at least 2+ meals daily; I will feed myself w/cueing and supervision x 90 days I will drink 1100 cc fluids/day x 90 days... I need adequate eating time during meals. I eat in the dining room for socialization and interaction with my table mates and other residents during meals... meal set up; cueing & supervision by staff at meals; fluid intakes are recorded and monitored daily." The following concerns were identified: a. Observation on 7/8/19 beginning at 6:23 PM showed the resident was at the dining room table with a plate of food in front of him/her. An unidentified staff member said the resident's name two times and the resident did not respond. The staff member did not provide any further verbal cues and did not attempt physical assistance with meals. The resident did not eat any of his/her meal. b. Review of a "Nutrition/Dietary Note" dated 6/24/19 and timed 11:43 AM showed "Note Text: WT. CHANGE: [Resident name] experienced significant wt. [weight] change from last month when [his/her] wt. was 171.8# [pounds] on 5/15/19. This month [his/her] wt. on 6/19/19 was 160.6#. Wt. loss was 11.2# & 6.5% wt. decline. [S/he] has been refusing meds and becoming upset with the past month. [S/he] also is not eating as well. [Resident name] is at a dining room table where [s/he] can receive assistance with eating. [S/he], however is not very accepting of actual eating assistance, but is there for verbal cueing and encouragement along with	F 692	Dietician and updated to include offering alternative meal options or supplements at meals and offering physical assistance. Staff has been reeducated on resident #58's care plan. Dietician will conduct random weekly audits during meal times, and will monitor weekly percentage meal of consumption and weekly weights to ensure nutritional status is being met. 2. All residents have the ability to be affected by maintaining an acceptable parameter of nutritional status, such as body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise. 3. All staff will be reeducated during an all staff meeting about the requirement for the residents to maintain an acceptable nutritional status on August 14, 2019. The Dietician will reeducate the staff on the alternative options to help maintain the resident's acceptable nutritional status. 4. The Care Center Nursing Director or designee will conduct random monthly audits of the care plans to ensure that the care plans are being followed to help ensure the residents maintain an acceptable nutritional status. The Care Center Nursing Director or designee will conduct random monthly audits of the staff during meal times. Audits will include if the resident needed any other additional queuing to eat if the resident was not eating and if they were offered any alternative meals or meal replacement shakes if needed. The audit data will be aggregated monthly	

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F 692	Continued From page 16 conversation. [Resident name] is offered a 4oz [ounces]. nutrition supplement BID [twice daily] between meals for poor meal intake. Follow as needed." c. Interview with the dietitian on 7/10/19 at 2:39 PM revealed the resident had stopped eating as much during meals due to his/her dementia progression and staff should attempt to provide verbal and physical assistance, offer alternative meals, and offer meal replacement shakes.	F 692	and reported quarterly to the Administrator, Medical Director, QAPI Steering Committee, and Quality Council. The QAPI Steering Committee will ensure overall compliance.	
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review,	F 700	1. The facility will attempt to use	8/25/19

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F 700	Continued From page 17 and staff interview, the facility failed to ensure bed rails were assessed for safety, and failed to obtain informed consent prior to installation for 4 of 4 sample residents (#12, #13, #19, #47) with bed rails. The findings were: 1. Review of the annual MDS assessment dated 4/2/19 showed resident #12 had diagnoses which included arthritis and non-Alzheimer's dementia, and required extensive physical assistance of 1 person for bed mobility and total physical assistance of 1 person for transfers. Review of the care plan last revised on 4/23/19 showed "I have impaired mobility r/t [related to] a disability in my lower extremities and confusion" and interventions included "Bed Mobility: I need extensive assistance with bed mobility and I will use two half side rails to assist with turning and repositioning." The following concerns were identified: a. Observation on 7/9/19 at 8:13 AM showed the resident had bilateral bed rails attached to the upper portion of his/her bed, which were designed with 5 gaps. The gaps measured 5 inches by 4 1/2 inches, 4 inches by 6 inches, 2 1/2 inches by 6 inches, 4 inches by 12 inches, and 2 1/2 inches by 12 inches. b. Review of the "side rail assessment" dated 7/9/19 showed no evidence the bed rails were assessed for risk of entrapment. c. Review of the medical record showed no evidence the resident signed a consent for bed rail use. 2. Review of the annual MDS assessment dated 4/9/19 showed resident #13 required extensive physical assistance of 1 person for bed mobility and had diagnoses which included hypertension, osteoporosis, and pain in right shoulder, left	F 700	appropriate alternatives prior to installing a side or bed rail. If a side or bed rail is used the facility will ensure the safety of the resident is met by conducting an assessment that will include: risk of entrapment, risk and benefit of bed rails with resident or resident representative and obtain consent prior to installation, ensure bed's dimensions are appropriate for the resident's size and weight, follow manufactures recommendations for installing and maintaining rails. Residents #12, #13, #19, #47 will have assessments done that will include their risk of entrapment and a signature of consent. 2. All residents have the ability to be affected by not having a bed rail assessment completed that includes risk of entrapment and also by not giving their written consent to use bed rails. All residents that currently use bed rails or who will potentially use bed rails, will have a bed rail assessment done to ensure safety. 3. The Care Center Nursing Director or designee will review and revise facility side rail assessment to include: risk for entrapment assessment and a resident or resident representative consent form. Reeducation and a review of the updated assessment will be given during an all staff meeting on August 14, 2019. . All residents with side rails will have an updated assessment completed to assess and document risk of entrapment, and consent by August 25th. All residents who use side rails care plans will be updated with the reason for use or refusal. 4. The Care Center Nursing Director or	

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F 700	Continued From page 18 shoulder, and low back. Review of the care plan last revised on 4/20/19 showed "I have mobility impaired r/t [related to] declining strength, balance, and coordination." The interventions included "Bed Mobility: Provide extensive assist with bed mobility especially helping with my legs in and out of bed. I does [sic] not use side rails. I has [sic] a grab bar." The following concerns were identified: a. Observation on 7/9/19 at 11:19 AM showed the resident had bilateral bed rails attached to the upper portion of his/her bed, which were designed with 5 gaps. The gaps measured 5 inches by 4 1/2 inches, 4 inches by 6 inches, 2 1/2 inches by 6 inches, 4 inches by 12 inches, and 2 1/2 inches by 12 inches. b. Review of the "side rail assessment" dated 4/12/19 showed no evidence the bed rails were assessed for risk of entrapment. c. Review of the medical record showed no evidence the resident signed a consent for side rail use. 3. Review of the annual MDS assessment dated 4/9/19 showed resident #19 had diagnoses which included non-Alzheimer's dementia, seizure disorder or epilepsy, and intracranial injury without loss of consciousness, and required total physical assistance of 1 person for bed mobility and transfers. The following concerns were identified: a. Observation on 7/9/19 at 9:05 AM showed the resident had bilateral side rails attached to the upper portion of his/her bed, which were designed with 5 gaps. The gaps measured 5 inches by 4 1/2 inches, 4 inches by 6 inches, 2 1/2 inches by 6 inches, 4 inches by 12 inches, and 2 1/2 inches by 12 inches. b. Review of the "side rail assessment" dated	F 700	designee will conduct assessments on all new admissions that need side rails to ensure compliance with the assessment of risk, and obtaining consent. The audit data will be aggregated monthly and reported quarterly to the Administrator, Medical Director, QAPI Steering Committee, and Quality Council. The QAPI Steering Committee will ensure overall compliance.	

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F 700	Continued From page 19	F 700		

4/12/19 showed no evidence the bed rails were assessed for risk of entrapment. Further review showed the side rails were not used to promote independence, were not requested by the resident, and did not appear to be indicated.

c. Review of the medical record showed no evidence the resident signed a consent for bed rail use.

d. Interview with the DON on 7/10/19 at 2:17 PM revealed the bed rails should not have been in use for the resident.

4. Review of the quarterly MDS assessment dated 5/14/19 showed resident #47 had diagnoses which included depression, bipolar disease, and malignant neoplasm of the upper left lung lobe, and required supervision of 1 person for bed mobility. Review of the care plan last revised on 5/22/19 showed "I have mobility impairment r/t [related to] advanced age, compromised breathing effectiveness and peripheral neuropathy" and interventions which included "Bed Mobility: I can use some supervision with my bed mobility and use one half side rail." The following concerns were identified:

a. Observation on 7/9/19 at 8:06 AM showed the resident had bilateral side rails attached to the upper portion of his/her bed, which were designed with 6 gaps. Two of the gaps measured 4 inches by 4 inches, two of the gaps measured 4 inches by 7 3/4 inches, and 2 of the gaps measured 4 inches by 11 inches.

b. Review of the "side rail assessment" dated 5/20/19 showed the facility did not assess the bed rail for risk of entrapment.

c. Review of the medical record showed no evidence the resident signed a consent for bed rail use.

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F 700	Continued From page 20 5. Interview with the DON on 7/10/19 at 2:06 PM revealed the facility did not evaluate resident side rails for entrapment risk.	F 700		
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 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	F 758		8/25/19

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F 758	Continued From page 21 §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 medical record review and staff interview, the facility failed to ensure PRN (as needed) orders for psychotropic drugs did not extend beyond 14 days for 1 of 5 sample residents (#50) reviewed for psychotropic medications. The findings were: Review of current physician orders showed resident #50 was prescribed lorazepam (anti-anxiety) 1mg-2mg, one-half hour prior to bathing, for agitation/aggression on 2/14/19. Further review of the orders showed a stop date had not been included. Review of the June and July 2019 MAR (medication administration record) showed the resident received the medication 4 times in June and 1 time between 7/1/19 and 7/10/19. Interview with the DON on 7/10/19 at 5:41 PM confirmed the resident's PRN medication did not have a stop date and he understood the rationale behind the regulation.	F 758	1. All residents who are given a psychotropic drug will receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. PRN orders for psychotropic drugs will be limited to 14 days unless the attending or prescribing physician believe the PRN order to be extended, then the rationale shall be documented in the resident’s medical record and indicate the duration for the PRN order. Resident #50 PRN psychotropic med has been reviewed and discontinued. 2. All residents using a psychotropic medication have the ability to be affected if the psychotropic medication is a PRN order without a stop date or a duration date. 3. Care Center Medical Director will reeducate the other primary care physicians about the requirement for psychotropic medications by August 25,	

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F 758	Continued From page 22	F 758	2019. All Nursing staff will be reeducated during an all staff meeting about this requirement for PRN psychotropic medications on August 14, 2019. 4. Pharmacist or designee will conduct monthly audits on psychotropic medications to ensure if a PRN psychotropic medication is prescribed, the physician has included a stop date or a duration date. The audit data will be aggregated monthly and reported quarterly to the Administrator, Medical Director, QAPI Steering Committee, and Quality Council. The QAPI Steering Committee will ensure overall compliance.	
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations;	F 791		8/25/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535045	A. BUILDING _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWELL VALLEY CARE CENTER	777 AVENUE H POWELL, WY 82435

(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 791	Continued From page 23 §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on resident representative and staff interview, and medical record review, the facility failed to ensure dental services were provided to 1 of 1 sample residents (#19) who had identified oral concerns. The findings were: 1. Review of the annual MDS assessment dated 4/9/19 showed resident #19 was coded "obvious or likely cavities or broken teeth and mouth or facial pain, discomfort or difficulty chewing. The following concerns were identified: a. Interview with the resident's representative on 7/9/19 at 1:52 PM revealed the resident had problems with his/her teeth and gums for a while and the facility was unable to obtain dental care. b. Review of the quarterly MDS assessment	F 791	1. The facility will assist all residents to receive routine dental services and emergency dental services when needed. Resident #19 will have a dental visit by August 14, 2019. 2. All residents could potentially be affected by not receiving routine or emergency dental services. Dietician will review the resident during the resident's quarterly oral MDS assessments for dental service needs. Nursing staff will be reeducated to look for symptoms when the residents eat, take medications, or complaining of mouth pain that would indicate dental services are needed on august 14, 2019.	

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F 791	Continued From page 24 dated 7/10/18 showed the resident had mouth or facial pain, discomfort or difficulty with chewing. c. Interview with the DON on 7/10/19 at 2:20 PM revealed if a resident had dental issues he expected the resident to receive dental consultation and care and he was unsure if the resident had received the care. d. Interview with the DON on 7/11/19 at 10:07 AM revealed he was unable to find documentation the resident was seen by a dentist or needed to be seen by a dentist. Further interview revealed the facility was not aware the resident needed to be seen by a dentist.	F 791	3. All staff will be reeducated during an all staff meeting about the Care Center policy for dental services on August 14, 2019. Care Center Nursing Director or designee will conduct weekly audits to determine if there are signs or symptoms that could indicate a need for dental services. If dental services are needed the Care Center Nursing Director or designee will contact a dentist to schedule an appointment. 4. Care Center Nursing Director or designee will collaborate with the Dietician to conduct random monthly audits to determine if the resident needs dental services. The audit data will be aggregated monthly and reported quarterly to the Administrator, Medical Director, QAPI Steering Committee, and Quality Council. The QAPI Steering Committee will ensure overall compliance.	