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 _____	08/12/2021

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F 000	INITIAL COMMENTS A recertification survey was conducted by Healthcare Licensing and Surveys from 8/9/21 to 8/12/21. The following common abbreviations are used throughout this document: DON: Director of Nursing CNA: Certified Nursing Assistant MDS: Minimum Data Set RN: Registered Nurse ADON: Assistant Director of Nursing MAR: Medication Administration Record TAR: Treatment Administration Record Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		9/17/21

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

Electronically Signed | 09/03/2021

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

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F 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, medical record review, and policy and procedure review, the facility failed to ensure 1 of 19 sample residents (resident #68) were treated with dignity and respect. The findings were: 1. Review of the 7/13/21 quarterly MDS assessment showed resident #68 was admitted to the facility on 4/9/20, had a BIMS score of 3 showing severely impaired cognition, was frequently incontinent, and had diagnoses that included other cerebral infarctions, other symptoms and signs involving the nervous system, type 2 diabetes mellitus without complications, thyrotoxicosis, restlessness and	F 550	1. The facility will ensure that all residents are treated with dignity and respect. 2. Review and education of resident #68 care plan and toileting plan, and providing care with dignity and respect will be completed with all staff. 3. All residents have the potential to be affected by a failure to ensure dignity and respect of each resident. In order to ensure no other residents were affected by deficient practice regarding dignity and respect, on 9/3/21 to 9/9/21 the Administrator and Administrator in Training conducted random auditing of cares and interactions between staff and	

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F 550	Continued From page 2 agitation, and vascular dementia without behavioral disturbance. Review of the current care plan, last revised 7/20/21, showed the resident had " ... FUNCTIONAL [sic] bladder incontinence r/t Impaired Mobility" and the resident was " ... totally dependent on one staff for toilet use. Please check and change me every 2 hours and PRN." Further review showed the resident had communication difficulties, but could answer basic or yes/no questions. The following concerns were identified: a. Observation on 8/11/21 at 11:49 AM showed the resident was seated in his/her wheelchair in the common area of the unit, along with two other residents. The resident was calling out "help" with each breath exhalation, indirectly asking "who are you?", as well as stating "I have to go to the bathroom." After stating a few times s/he had to use the bathroom, RN #1 approached the resident to acknowledge the request. The nurse appeared confused and turned to ask CNA #1 about how to care for the resident. CNA #1 was seated at the nurse's station across the room; she then stood up and loudly expressed "[S/he]'s a check and change. [S/he] can just go in [his/her] pants since [s/he] has depends on, and they'll change [him/her] later." RN #1 said okay, and returned to the medication cart, and CNA #1 returned to the nurses station. The resident continued to call out, stating again s/he needed to use the bathroom at 11:51 AM and 11:54 AM. RN #1 again approached the resident, moved the resident to a table, and sat down next to the resident to assist him/her with lunch. The resident again began stating s/he needed to go to the bathroom, to which RN #1 responded "You can just go right here. You can just go in your pants and we'll change you after lunch. Just go." b. Observation on 8/11/21 at 6:00 PM showed	F 550	residents to ensure dignity and respect. 4. Measures implemented to ensure deficient practice will not recur include education regarding residents rights and showing/maintaining dignity including appropriate use of words and providing care in accordance with the care plan will be provided to all nurse staff at upcoming Nursing meeting on 9/15/2021. The education will also be included to all staff upon hire. 5. Monitoring to ensure compliance and solutions are sustained will include random weekly audits of resident interactions to ensure respect/dignity and care in accordance with the care plan. 6.Results will be aggregated monthly and reported quarterly to QAPI steering committee, CC Med Director, and CC Administrator. QAPI committee has ultimate responsibility to ensure compliance and if concerns are identified QAPI committee makes recommendations to ensure compliance.	

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F 550	Continued From page 3	F 550		

CNA #2 transferred the resident to his/her bed using a mechanical lift. She then removed the resident's brief, and it was noted the resident had been incontinent of both bowel and bladder. Interview with CNA #2 at the time revealed she did not usually work in that area of the facility and did not know if the resident was always incontinent.

c. Interview with CNA #1 on 8/12/21 at 10:55 AM revealed residents designated a "check and change" were residents who were incontinent, and required staff to change their brief every 2 to 4 hours because these residents don't use the toilet. She then provided the basic care sheets the staff use as a reference during their shifts; it contained guidance for transfers, notes, and resident-specific accommodations. It was noted that 6 other residents were noted as being "Ck & chg"; CNA #1 confirmed this stood for "check and change." She stated staff " ... know [the residents] are incontinent so [staff] only change their briefs, so we don't actually toilet residents with briefs, because that's considered [the resident's] toileting."

d. Interview with the DON on 8/12/21 at 12:36 PM revealed all residents should be asked or assessed for toileting needs at least every 4 hours. She further stated if a resident is physically able to sit on the toilet, then the resident should be toileted; a resident who was unsafe or physically unable to sit on the toilet would be a "check and change." She also stated her expectation was for staff to assist a resident to the bathroom if the resident requested. The DON stated it would not be appropriate to tell residents to soil themselves and they would change them later, nor to refer to residents as a "check and change".

e. Review of facility policy "Patient and

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F 550	Continued From page 4 Resident Rights", last revised February 2019, showed residents have the "Right to Participate in One's Own Care: Receive adequate and appropriate care ...", "Right to Privacy and Confidentiality: During treatment and care of one's personal needs ..." , and the "Right to Dignity, Respect ,and Freedom: To be treated with consideration, respect, and dignity ..."	F 550		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must	F 585		9/17/21

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F 585	Continued From page 5 include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the	F 585		

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F 585	Continued From page 6 provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident representative and staff interview, medical record review, and policy and procedure review, the facility failed to ensure resolution to grievances for 1 of 1 sample residents (#11) who reported lost items. The findings were: 1. Review of a psychosocial note dated 3/10/21 and timed 10:57 AM showed resident #11's "plain gold wedding band" was missing and the resident's spouse was "very upset." Interview with the resident's son on 8/10/21 at 4:27 PM revealed the wedding ring remained missing and there was	F 585	1. The facility will ensure follow-up and resolution to grievances from residents/families. 2. The lost item for resident # 11 remains missing. Follow- up with resident son completed by social worker on 9/10/21. 3. All residents have the potential to be affected by failure to follow-up and ensure resolution to concerns/grievances. In order to ensure no other residents are affected by the deficient practice the social worker conducted a 100% audit of the grievance log January 1, 2021 to	

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F 585	Continued From page 7 no resolution at that time. Review of the grievance log showed no evidence a grievance form was completed for the missing ring. Interview with the social services director on 8/12/21 at 8:17 AM confirmed she was aware of the missing ring and the facility had not resolved the grievance. Further interview revealed the facility would consider anything that "bothered" a resident to be a grievance. 2. Review of the policy titled "Patient Complaints/Grievances" dated 08/2020 showed "...Definitions:...II. Patient/Resident Grievance A. A "grievance" is defined as a formal or informal written or verbal complaint that is made by a patient/resident or the patient/resident's representative when a patient/resident issue cannot be resolved promptly by staff present...V. Timelines for Grievance Response...D. If the grievance is not complete and/or corrective action is still being evaluated, the facility response should communicate the status of the resolution process and will provide a follow-up date in writing within 14 days after submission. PVHC should attempt to resolve all grievances as soon as possible..."	F 585	present date to ensure/validate appropriate follow-up/resolution. 4.Measures implemented in order to ensure deficient practice wont recur include education to the staff on the facility grievance policy including the definition of grievance per the policy, process, and reporting so that the incident can be logged to ensure follow-up and resolution. Education will take place at the next staff meeting on Sept 15, 2021. Education regarding grievances process and policy will also be provided upon hire. 5. Monitoring to ensure compliance includes weekly auditing of the grievance log to ensure appropriate follow-up and resolution to the concerns logged. 6. Information will be aggregated monthly and reported quarterly to QAPI steering committee, CC Med Director, and CC Administrator. QAPI committee has overall responsibility to ensure compliance and will make recommendations if there are concerns to ensure compliance.	
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	F 637		9/17/21

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F 637	Continued From page 8 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, staff interview, and review of the CMS MDS 3.0 Resident Assessment Instrument (RAI) manual, the facility failed to ensure a significant change assessment was completed for 1 of 3 sample residents (#41) with an identified change in condition. The findings were: 1. Review of the annual MDS assessment dated 3/16/21 showed resident #41 had a BIMS score of 6 out of 15 indicating the resident had severe cognitive impairment. The resident had diagnoses which included non-Alzheimer's dementia, anxiety disorder, cerebrovascular accident, and seizure disorder. Further review showed the resident weighed 181 pounds with no weight loss greater than 5 percent in the last month or 10 percent in the last 6 months and was able to eat independently. The following concerns were identified: a. Review of the quarterly MDS assessment dated 6/15/21 showed the resident had a BIMS score of 4 out of 15 indicating severe cognitive impairment and required total physical assistance of 1 person for eating. Further review showed the resident weighed 162 pounds, a 10 percent weight loss since the annual assessment, and was shown to have weight loss which was not physician prescribed. b. Interview with the MDS coordinator on 8/12/21 at 8:57 AM revealed she had missed the resident's weight loss and with the decline in eating the quarterly MDS assessment should	F 637	1. The facility will ensure significant change in status assessment is completed for residents with an identified change in status of 2 or more areas. 2. A significant change in status assessment has been completed for resident # 41 and the plan of care has been updated to reflect the changes. 3. All residents have the potential to be affected by failure to complete a new assessment when experiencing significant decline in 2 or more areas. In order to ensure the deficient practice will not recur the MDS Coordinator conducted a random audit of the focused documentation list for the previous 3 months to ensure no residents were identified to have areas of decline in 2 or more areas requiring a significant change in status assessment. 4. Measures implemented to ensure deficient practice will not recur includes education of MDS team regarding the need to closely monitor and implement a significant change with 2 areas of change in accordance with RAI manual. 5. Monitoring to ensure compliance will include the MDS coordinator or designee conducting a daily review of all residents on focused documentation list during daily huddle to identify residents for potential significant change assessment. Residents noted to have a decline will be reviewed	

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F 637	Continued From page 9 have been a significant change assessment instead, since there were 2 identified areas decline. c. Review of the CMS "Long-Term Care Facility Resident Assessment Instrument 3.0 User ' s Manual version 1.17.1" last revised October 2019 showed "...A "significant change" is a major decline or improvement in a resident ' s status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "self limiting"; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan..."	F 637	by IDT for 2 areas of change and proceed with Significant change. 6.Information from audit findings will be aggregated monthly and reported quarterly to QAPI steering committee, CC Med Director and CC Administrator. QAPI has overall responsibility to ensure compliance and will make recommendations if concerns arise to ensure compliance.	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and CMS MDS 3.0 Resident Assessment Instrument (RAI) review, the facility failed to ensure MDS assessments were completed a minimum of every 92 days for 1 of 20 sample residents (#1). The findings were: 1. Review of the admission MDS assessment for resident #1 showed the assessment was completed on 3/28/21. Review of the following quarterly MDS assessment showed the assessment was completed on 7/27/21, 121 days after the completion of the admission	F 638	1. The facility will ensure resident MDS assessment is completed on time in accordance with the MDS 3.0 Resident Assessment Instrument (RAI). 2. The late assessment for resident # 1 occurred in the past and cannot be corrected. 3. All residents have the potential to be affected by failure to ensure the resident MDS assessment is completed on time. In order to no other residents were affected by the deficient practice the MDS Coordinator conducted an audit of the	9/17/21

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F 638	Continued From page 10 assessment. 2. Interview with the MDS coordinator on 8/12/21 at 9:01 AM revealed she was aware the resident's quarterly MDS assessment was completed late. The MDS coordinator revealed the resident was left off the planning schedule at the time the quarterly assessment was due. 3. Review of the CMS "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual version 1.17.1" last revised October 2019 showed "...The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all MDS items appear on the Quarterly assessment. The ARD [assessment reference date] (A2300) must be not more than 92 days after the ARD of the most recent OBRA assessment of any type..."	F 638	scheduled MDS for the previous 3 months to ensure no assessments were late and out of compliance with RAI manual instructions. 4. Measures implemented to ensure the deficiency will not recur include MDS Coordinator to implement monitoring of scheduled assessments by reviewing schedules preceding every upcoming month. 5. Monitoring to ensure compliance will include MDS Coordinator or designee conducting a monthly audit of the MDS calendar of assessments due to ensure accurate dates for completion. 6. The information will be aggregated monthly and reported to QAPI steering committee, CC Med Director, and CC Administrator. QAPI committee has ultimate responsibility to ensure compliance and make recommendations if concerns present to ensure compliance.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		9/17/21

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F 686	Continued From page 11 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, medical record review, and policy and procedure review, the facility failed to ensure treatment and services were provided to promote healing of pressure injuries for 1 of 6 sample residents (#228) with pressure injuries. The findings were: 1. Review of the 7/22/21 admission MDS assessment showed resident #228 was admitted to the facility on 7/16/21 with diagnoses that included malignant neoplasm of unspecified site of unspecified breast, and age-related osteoporosis without current pathological fracture. Further review showed the resident was cognitively intact with a BIMS score of 15, required supervision with bed mobility, and limited assistance of 1 person with transfers and toilet use. Review of the 7/16/21 Braden Scale assessment showed the resident was at risk for pressure sore development with a score of 18. Review of the resident's current care plan, last updated 8/3/21, showed the resident was at risk for pressure ulcer development, with interventions that included "Follow facility policies/protocols for the prevention/treatment of skin breakdown" and " ...calmo/minerin/A&D cream applied after peri-care to help maintain my skin integrity." Review of an admission summary progress note dated 7/16/21 and timed 3:46 PM showed " ... Over all skin is dry and intact ... Coccyx is pink as she sits a lot ..." Review of a skin/wound progress note dated 7/26/21 and timed 5:03 PM showed " ... [the resident's] skin was clean, dry, and intact	F 686	1. The facility will ensure that residents receive care to prevent pressure ulcers and a resident with pressure ulcers receives necessary treatment and services to promote healing and prevent infection and prevent new ulcers from forming. 2. The Treatment Administration Record for resident # 228 has been updated to include current treatment for pressure ulcers as well as weekly wound assessment. 3. All residents have the potential to be affected by failure to ensure care and services to prevent and or heal pressure ulcers. In order to ensure no other residents were affected by the deficient practice a random audit of residents with skin issues will be completed by 9/15/21 to ensure initial wound assessment, progress note, treatment and weekly skin assessment has been completed and treatment/assessment added to the resident treatment administration record (TAR). 4. Measures that will be implemented to prevent deficiency form recurring include nursing staff education to ensure that the initial wound assessment progress note is completed upon discovery of any new wound. Wound treatment will be initiated upon discovery of new skin/wound issue and will be added to the resident TAR and the weekly wound assessment is added to	

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F 686	Continued From page 12 ..." The following concerns were identified: a. Review of a nursing 8/4/21 skin/wound progress note timed 6:02 AM showed " pt has a stage 2 pressure ulcer on coccyx ... Area was clean, dried, and barrier cream applied." Review of another nursing skin/wound progress note, documented by a second nurse, dated 8/4/21 and timed 3:37 PM showed "Resident has Stage 2 open ulcer to L side of coccyx, and redness to R side of coccyx. Bacitracin [antibiotic ointment] applied to open sore and covered with Mepelex [padded wound bandage]. Wound Care RN was notified of the ulcers." b. Review of an Initial Wound Assessment progress note dated 8/7/21 and timed 3:18 PM documented a left buttock pressure ulcer measuring "3 [by] 3 [by] 0", with no units of measure indicated. The wound was described as having a "Pink/beefy Red Tissue" wound bed, and macerated wound edges/surrounding tissue. Documented wound treatments initiated included " ... cleansed with wound wash, A&D and calmoseptine applied, mepilex ..." The note further showed the physician was notified on 8/7/21 at 3:00 PM, and wound care was notified on 8/7/21 at 2:00 PM. The note also showed "Wound Treatment Added to TAR" and "Weekly Wound Assessment Added to TAR" were both documented as "No". c. Observation of wound care performed by wound care nurse on 8/12/21 at 11:23 AM showed the nurse approached the resident, who had just finished using the toilet, and assisted him/her to his/her feet. Upon standing, two open wounds were observed on the inner side of both of the resident's buttocks. The wound on the left buttock was noted to be approximately three inches across, was open with a visible wound bed, and very raw and reddened. The wound on	F 686	the TAR to ensure appropriate follow up, treatment and interventions. 5. Audits will be conducted by Wound care nurse or designee to ensure initial assessment, treatment/interventions, and weekly skin assessments are completed for all residents with wound issues/pressure ulcers. 6. Information/results from the audits are aggregated monthly and reported quarterly to QAPI steering committee, CC Medical Director, and CC Administrator. QAPI committee has overall responsibility to ensure compliance and make recommendations if concerns arise to ensure compliance.	

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F 686	Continued From page 13	F 686		

the right buttock cheek was smaller, was very reddened, and appeared to have minor skin breakdown. The resident stated at the time the wounds were painful and irritated. Both wounds were cleansed and had ointment applied, and a Mepelex covering was applied to the wound on the left buttock; the wound on the right was not covered with a dressing. Interview with the wound care nurse at that time revealed she was aware of the wounds, but had not assessed or intervened immediately after she was notified of their presence; she was unable to recall the exact date of the notification.

d. Review of the current physician orders revealed no treatment orders or interventions for the identified wounds. Review of the July 2021 and August 2021 MAR and TAR showed no documentation of orders or treatments provided to the identified wounds.

e. Review of the medical record showed after discovery on 8/4/21, no documented monitoring or assessments were performed on the wounds until 8/7/21; further review showed no additional documentation was noted after the initial wound assessment on 8/7/21.

2. Review of the policy titled "Wound Care Guidelines-Prevention of Pressure Ulcers and Skin Tears" dated 8/2019 showed "...A. Acute Care: When a nurse identifies a wound or pressure ulcer, he/she should obtain a physician's order for a wound nurse consult. Long Term Care: When a nurse identifies a wound or pressure ulcer, he/she should notify the wound care nurse. B. The wound care nurse, or other qualified RN, will do an initial assessment. Documentation to include: photographs of the wound, wound measurement, wound description and treatment recommendations. This nurse will

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F 686	Continued From page 14 collaborate with the physician for treatment orders..."	F 686		
F 692 SS=G	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, medical record review, and policy and procedure review, the facility failed to provide services to ensure residents maintained acceptable parameters of nutritional status for 1 of 4 sample residents (#40) with weight loss. This failure resulted in harm to resident #40, who experienced an avoidable 7.6% loss of body weight in a 53 day period. The findings were:	F 692	1. The facility will ensure services are provided to maintain acceptable parameters of nutritional status. 2. Resident # 40 expired. 3. 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 residents clinical condition demonstrates	9/17/21

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F 692	Continued From page 15 1. Review of the admission MDS assessment dated 6/10/21 showed resident #40 had a BIMS score of 8 out of 15, indicating the resident had severe cognitive impairment and diagnoses which included arthritis, non-Alzheimer's dementia, and "other fracture." Further review of the MDS assessment showed the resident had no identified weight loss, no swallowing issues, and required supervision of 1 person for eating. Review of the self-care performance deficit care plan last revised on 6/14/21 showed interventions which included "...Eating: I am able to eat with supervision and set up by one staff member." Further review of the care plan showed a focus area dated 6/15/21 indicating the resident had the potential for chewing difficulties due to a lack of teeth or dentures, and a focus area dated 6/22/21 that indicated the resident was at risk for dehydration and was to be weighed every Wednesday. The following concerns were identified: a. Further review of the resident's medical record showed between 6/14/21, when the resident's weight was recorded as 122.4 pounds, and 8/6/21, when the resident's weight was recorded as 113 pounds, the resident lost 9.4 pounds (7.6% of body weight) over the 53-day period. b. Review of the nutrition/dietary note dated 6/24/21 showed "WT. LOSS: [resident's] most current wt. [weight] on 6/23/2021 was 118.0 Lbs. This is a -5.8% & -7.2 Lb. wt. decline in 2 weeks from a wt. of 125.2 Lbs on the 9th. [The resident] has pain daily and has experienced a fall in addition to [his/her] dementia. Wrote order for approved nutrition supplement BID [twice daily] between meals. Monitor weekly wts and follow as needed." c. Review of the nutrition/dietary note dated	F 692	that this is not possible or resident preferences indicate otherwise. In order to ensure no other residents are affected by deficient practice, the Dietician will conduct a review by 9/15/21 of all resident assessment, care plans and care plan interventions for the month of August to ensure services were provided to maintain acceptable parameters of nutrition. 4. Measure implemented to ensure deficient practice wont recur includes staff reeducation during an upcoming staff meeting about the requirement for the residents to maintain an acceptable nutritional status. The Dietician will be educated to update the nutrition care plan to reflect any new interventions or changes when a resident experiences a decline in nutrition/hydration status. will reeducate the staff on the alternative options to help maintain the residents acceptable nutritional status. Staff will be reeducated on the importance of offering additional verbal cues or physical assistance, offering alternative meals or meal replacement shakes. 5. Monitoring to ensure compliance by the Dietician or designee will randomly audit the care plans to ensure that the care plans are being followed to help ensure the residents maintain an acceptable nutritional status. Dietician 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.	

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F 692	Continued From page 16 7/29/21 showed "SIGNIFICANT WEIGHT LOSS: [resident's] weight on 7/15/21 was 118.4#. This is a weight loss of 6.8#/5.4% since 6/9/21. Average meal intake for the last 4 weeks have declined from 53% to 17%. Nursing staff report due to [his/her] declining health condition, [resident] is eating and drinking very little. Current diet order is mechanical soft, nectar thickened liquids. Nutrition supplement order for BID between meals." d. Further review of progress notes and the resident's care plan showed no other interventions related to the resident's weight loss, and no change or update to the assessment the resident required only supervision and set up with meals. e. Observation on 8/9/21 at 5:27 PM showed the resident was in his/her wheelchair, seated at a table with two other residents in the common dining area. The resident was slumped forward in his/her chair, leaning to the left. It was noted a spoon was on the plate; however, minimal food had been eaten. f. Observation on 8/10/21 at 12:03 PM showed a CNA positioned the resident up to the table and left the room. The resident's head was leaned forward and his/her eyes were closed. The resident's meal tray was uncovered and positioned on the table in front of the resident. Observation at 12:08 PM showed dietitian #1 attempted to wake the resident without success. The dietitian notified a CNA the resident was not eating. Observation at 12:13 PM showed the dietitian obtained a drink that was orange in color and attempted to assist the resident to eat. g. Observation on 8/10/21 at 5:22 PM showed the resident was seated at an assisted dining table, which was a different location than his/her previous meals, and was being assisted	F 692	6. The audit data will be aggregated monthly and reported quarterly to QAPI steering committee, CC Med Director and CC Administrator. QAPI has overall responsibility to ensure compliance and make recommendations if concerns arise to ensure compliance.	

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F 692	Continued From page 17 by staff to eat the meal. h. Observation on 8/11/21 at 12:01 PM showed the resident was seated at an assisted dining table and was eating independently. i. Interview with the dietitian on 8/12/21 at 8:49 AM revealed when the resident's initial assessment was performed, his/her actual weight was 122.4 pounds. The dietitian revealed when residents were identified for weight loss, they were reviewed monthly, and weights were also discussed during team meetings. Further interview revealed the dietitian had noticed the resident was slumped over in the chair and was not receiving assistance on 8/10/21, so she attempted to assist him/her. She revealed one of the CNAs reported she could not get the resident wake up; however, the dietitian was able to wake the resident and helped him/her eat. The dietitian confirmed the resident's meal intakes were low, and the resident was placed at the assisted table due to the low intake averages. The dietitian revealed the resident's dining assistance needs should be indicated on the care plan, and she felt the resident needed someone to sit with him/her to help during meals. j. Review of the policy titled "Resident Weight Maintenance" dated 8/19 showed "...Every effort will be made within the range of resident wishes/rights to maintain a healthy weight for each resident...III. The charge nurse responsible for the resident with weight loss will be notified. Nursing will be asked to notify CNAs responsible for the day to day care of the resident. VII. Staff will review consumption records and eating pattern will be reviewed...IX. The nutrition care plan will be revised to reflect any new interventions or changes..."	F 692		
F 697 SS=D	Pain Management	F 697		9/17/21

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F 697	Continued From page 18 CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview the facility failed to ensure indications of pain were acted on for 1 of 6 sample residents (#42) reviewed for pain. The findings were: Review of the 6/15/21 quarterly MDS assessment showed resident #42 had diagnoses that included dementia. The resident had a BIMS score of 4 out of 15 which indicated severe cognitive impairment, and no pain was present at the time of the assessment. Review of the 12/22/20 care plan showed the resident had potential for pain related to a history of a lumbar compression fracture. The interventions included assessing for pain every shift and as needed and documenting the assessment in the MAR. "If I [the resident] show signs or symptoms of pain ask if I [the resident] would like something for it, either pharmacological or non-pharmacological." Review of the physician orders showed the pain medication "Tylenol tablet 325 mg give 2 tablets by mouth every 4 hours as needed" was available with a start date of 12/30/20. There were no other orders for pain medications. Interview with RN #2 on 8/12/21 at 9:20 AM revealed the resident was able to use words and verbalize how s/he was feeling. However, due to the resident's dementia the Pain Assessment in Advanced Dementia	F 697	1. The facility will ensure that indications of pain are acted on and pain management provided to residents who require these services. 2. Staff re-educated regarding resident # 42 current plan of care and treatment interventions for managing reported or observed signs of pain. 3. All residents have the potential to be affected by failure to act on any indications of pain and provide pain management. In order to ensure that no other residents are affected by the deficient practice, the MDS Coordinator will conduct random audit of residents receiving pain medication by 9/15/21 to ensure pain assessment, and management including appropriate interventions were implemented with the presence of pain. 4. Measures implemented to ensure the deficiency does not recur includes all staff education at upcoming staff meeting on Sept 15th regarding facility policy and procedure related to pain assessment and management including PAIDAD scale and interventions. 5. Monitoring to ensure compliance will be done by Care Center Nursing Director or	

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F 697	Continued From page 19 (PAINAD) tool was used to determine a number for the pain rating. The tool allowed the staff to identify current behaviors that could indicate pain. Review of the scale for the PAINAD tool showed 1-3 was mild; 4-7 was moderate and 8-10 was sever pain. The following concerns were identified: a. Observation on 8/10/21 at 9:32 AM showed the resident was grinding his/her teeth while seated in the recliner in the main area. Interview with RN #3 at that time revealed the resident was known to grind his/her teeth, and had been to the dentist recently. She further stated they checked with the resident routinely to rule out pain. Observation on 8/10/21 at 2:52 PM showed the resident was seated in a recliner in the main area, again grinding his/her teeth. The grinding could be heard from across the room. b. Review of an order administration note dated 7/31/21 at 8:08 AM showed "Tylenol Tablet 325 MG Give 2 tablet by mouth every 4 hours as needed...resident is grinding his teeth more than normal. When asked [s/he] stated 'I just hurt a little.'" c. Review of the July 2021 MAR showed the resident was assessed for pain three times per day (each shift). It was noted there were 21 separate assessments in which pain was indicated. The pain was indicated with a number from the (PAINAD rating tool) the numbers ranged from 1 to 6. Continued review showed the resident received the Tylenol on 5 of the 21 occasions pain was indicated. Further review or the MAR and the progress notes showed the resident did not receive any other pain medications or non-pharmacological pain interventions for the other 16 occurrences of documented pain. d. Review of the August 2021 MAR showed	F 697	designee by conducting monthly random audits of shifts assessment of residents indicating pain and intervention/treatments to address the pain. 6. This information will be aggregated monthly and reported quarterly to QAPI steering committee, CC Med Director and CC administrator. QAPI committee has overall responsibility to ensure compliance and make recommendations if concerns arise to ensure compliance.	

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F 697	Continued From page 20 the resident was assessed for pain three times per day (each shift). From 8/1/21 to 8/11/21 it was noted there were 14 separate assessments in which pain was indicated. The pain was indicated with a number from the (PAINAD rating tool) the numbers ranged from 2 to 5. Continued review showed the resident received the Tylenol on 1 of the 14 occasions pain was indicated. Further review or the MAR and the progress notes showed the resident did not receive any other pain medications or non-pharmacological pain interventions for the other 13 occurrences of documented pain. e. Interview with the DON on 8/12/21 at 12:39 PM verified there should have been follow through when pain was indicated on the shift assessments. Further, she was planning to complete an audit regarding the pain evaluation system.	F 697		
F 700 SS=D	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.	F 700		9/17/21

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F 700	Continued From page 21 §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, staff interview, and medical record review, the facility failed to ensure bed rail assessments indicated safe use for 1 of 3 sample residents (#11) with bed rails. The findings were: 1. Review of the quarterly MDS assessment dated 5/11/21 showed resident #11 had a BIMS score of 7, indicating severe cognitive impairment, had diagnoses which included non-Alzheimer's dementia and "other fracture," and did not use bed rails. Further review showed the resident required total physical assistance of 1 person for bed mobility, locomotion on and off the unit, dressing and personal hygiene and required total physical assistance of 2 or more people for transfers and toilet use. Review of the ADL self-care performance deficit care plan last revised on 2/18/21 showed interventions which included "...Bed Mobility: I require total assistance of one staff to turn and reposition in bed as necessary..." Further review showed the resident was "...a High risk for falls r/t [related to] Gait/balance problems and weight bearing as tolerated." The following concerns were identified: a. Observation on 8/10/21 at 9:32 AM showed the resident was in bed with a mattress on the floor to the right side of the bed, and half bed rails were in use to the bilateral upper portion of the bed. b. Observation on 8/11/21 at 5:27 PM showed	F 700	1. The facility will ensure appropriate use of bed/side rails, attempt to use alternative prior to installing a side or bed rail and ensure correct installation, use and maintenance of the bed rails. 2. The side rail risk assessment for resident # 11 was redone with an indication for use of side rails related to improvement of bed mobility and use for increase mobility while in bed. Family was informed of benefits/risks and informed consent was obtained. Restorative nurse ensured the beds dimensions are appropriate for resident size and weight and that we are following manufacturers guidelines/specifications for maintaining bed rails. 3. All residents have the potential to be affected by failure to ensure appropriate use of side rails. In order to ensure no other residents were affected by the deficient practice the Restorative nurse will conduct an audit by 9/15/21 of resident's using side rails to ensure the assessment supports indication for safe use of bed rails and that beds dimensions are appropriate for resident size and that we are following manufacturers guidelines/specifications for bed rails. 4. Measures implemented to prevent deficiency form recurring includes staff	

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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 700	Continued From page 22 the bed rails were in use on the bilateral upper portion of the bed. c. Observation on 8/12/21 at 8:53 AM showed the bed rails were designed with 5 gaps. Maintenance staff member #1 measured the gaps to be 3 3/4 inches by 12 inches, 2 1/4 inches by 12 inches, 6 inches by 4 inches, 6 inches by 2 1/2 inches, and 4 3/4 by 2 1/2 inches. d. Review of a side rail assessment form dated 6/4/21 showed the resident had an alteration in safety awareness, had a history of falls, had difficulty with balance or poor trunk control, received medications which may require safety precautions, and was visually impaired. Further review showed side rails should not be used and were not indicated at that time. e. Interview with nurse manager #1 on 8/12/21 at 9:52 AM revealed the resident was getting stronger and used the rails to sit up and reposition in bed. Further interview revealed she believed the rails were appropriate; however, she was unsure why the assessment indicated the resident did not need them.	F 700	education at upcoming staff meeting on September 15th need to ensure appropriate use of side rails including appropriate alternative, correct installation and maintenance if indicated per assessment. 5. Monitoring to ensure compliance will include audits to be completed monthly by Restorative nurse to ensure risk assessments coincide with residents indicated for use of side rails as well as resident bed rails to ensure they meet specification for avoidance of entrapment guidelines. 6. Information will be aggregated monthly and reported quarterly to QAPI steering committee, CC Med Director, and CC Administrator. QAPI committee has overall responsibility to ensure compliance and make recommendation if concerns arise to ensure overall compliance.	