

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/25/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>025015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/08/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>WRANGELL MEDICAL CENTER LTC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>P.O. BOX 1081 WRANGELL, AK 99929</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  The following deficiencies were noted during an unannounced recertification Medicare/Medicaid survey conducted 4/4/16 - 4/8/18. The sample included 6 active residents, 2 closed records and 2 non-sampled active residents.  Department of Health and Social Services Division of Health Care Services Health Facilities Licensing and Certification 4501 Business Park Blvd, Ste 24, Bldg L Anchorage, Alaska 99503	F 000		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS  The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.  Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.  The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		5/23/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/02/2016

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 164	<p>Continued From page 1</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>.</p> <p>Based on observation and policy review the facility failed to ensure: 1) personal privacy and confidentiality of personal care items were maintained for all residents, based on a census of 14; and 2) privacy and confidentiality were maintained during eye exams for 1 non-sampled resident (#9) and 1 sampled resident (#3) out of a total census of 14 residents. Specifically, an outside provider examined the residents and discussed medical conditions and treatment with the resident #9 in the common sitting area and with Resident #3 in the dining room while other residents and staff were present. As a result, the privacy and confidentiality of the residents' personal health conditions and information were violated. Findings:</p> <p>Private Information (Charge Sheets):</p> <p>An observation of Resident's rooms on 4/4/16 at 4:05 pm revealed, Residents' sensitive information was found to be posted on the outside of their bathroom doors. Specifically, the process by which Residents are charged for personal care products was in view of visitors and/or other Residents. Items such as briefs,</p>	F 164	<p>All resident rooms have been audited for any visible documents that displayed confidential or personal information. Other than personal care charge sheets, no other privacy or confidentiality issues were discovered. All charge sheets were immediately removed from the outside of resident doors. Charge sheets will now be placed on the back of resident doors with a cover sheet covering the charges to ensure the privacy of all our residents. The Director of Nursing of Long Term Care will ensure that random audits are conducted at least bi-monthly to ensure that resident's personal information is being kept private. This will be added to the Long Term Care quality calendar for continued observation and in effect by 05/23/2016.</p> <p>Upon receipt of this notification, an audit was done to ensure that any and all impending exams were scheduled to be done in the visiting physician's area or in the privacy of the resident's own room. Nursing staff will be in-serviced that all future exams of residents will be done in the privacy of their own rooms or in the visiting physician's area</p>		

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F 164	<p>Continued From page 2</p> <p>gloves and various creams could be seen on the charge/billing sheet, along with the Residents' full name, date of birth, medical record number, physician, and admission date.</p> <p>Eye Examinations:</p> <p>Resident #9</p> <p>During an observation on 4/5/16 at 11:10 am an outside provider conducted an eye exam on Resident #9. During the exam, information about the Resident's condition and deteriorating eyesight and options for interventions were discussed in the common sitting area outside other Resident's rooms.</p> <p>Resident #3</p> <p>During an observation on 4/5/16 at 3:00 pm an outside provider conducted an eye exam on Resident #3 in the dining area during a bingo game. During the exam, information about the Resident's condition and options for interventions were discussed out loud.</p> <p>During an interview on 4/7/16 at 10:15 am the Chief Nursing Officer (CNO) stated privacy is something residents have brought up, and the facility has talked about privacy in staff meetings.</p> <p>Review of the facility provided document "A Matter of Rights, A Guide to Your Rights and responsibilities as a Resident," last dated 2014, revealed "Your right to privacy and confidentiality is as important to you as it is to any other person. You have the right to...confidentiality for your personal and health information...Our policies and</p>	F 164	<p>The Director of Nursing of Long Term Care will randomly audit during scheduled physician exams to ensure that resident's aren't being examined or interviewed except in a private space.</p> <p>All credentialed physicians will be reminded to perform all resident exams and interviews in the privacy of the resident's room or in the designated, private visiting physician area.</p> <p>This will be completed by 05/23/2016.</p>		

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F 164	Continued From page 3 procedures addressing privacy and confidentiality are: A resident is entitled to privacy in...medical treatment...personal care, visits..."	F 164			
F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview the facility failed to ensure dignity in the areas of: 1) dining room experience for 4 residents (#'s 2, 4, 5 and 10); 2) eating for 2 residents (#'s 4 and 5) who were dependent on staff assistance with meals; 3) personal care for 1 resident (#4); 4) privacy during personal cares for 1 resident (#4); and 5) showers for 2 residents (#'s 1 and 3). These failures had the potential to affect 4 out of 5 sampled residents who's cares were observed. The manner and atmosphere in which residents are treated can potentially affect their quality of life. Findings:</p> <p>Dining room experience:</p> <p>During a continuous observation on 4/6/16 at 6:20 am to 8:45am in the dining area Resident #5 was observed to be sitting at the table in his/her wheelchair with head down and eyes closed.</p>	F 241	<p>If residents are observed sleeping in the dayroom, staff will attempt to arouse them. If a 2nd attempt to awaken is required, the resident will be offered to return to their room at that time. If the resident is unable to verbalize whether or not they would like to return to their room and they continue to be drowsy or sleeping, staff will return the resident to their room to rest.</p> <p>The CNA staff will received an in-service on 05/05/2016 regarding appropriate techniques when assisting residents with their meals. They were specifically reminded that it is not appropriate to wipe resident's mouths with anything other than a napkin.</p> <p>The Director of Nursing of Long Term Care will ensure rounds are made daily between 0730 and 1030 for two weeks</p>	5/23/16	

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F 241	<p>Continued From page 4</p> <p>During a continuous observation on 4/5/16 from 7:00 am to 8:30 am Resident (#s 2, 4, 5, and 10) were seated at the table in their wheelchairs with their eyes closed and heads down. Breakfast trays were delivered at 8:30 am. Residents were awoken by staff as meals were placed in front them.</p> <p>During additional observations during the meal at 8:30 am revealed all 4 residents had to be awakened several times to eat.</p> <p>During an interview on 4/7/16 at 10:15 am the Chief Nursing Officer (CNO) and the Assistant Chief Nursing Officer (ACNO) stated it was their understanding that Certified Nursing Assistants (CNA) and activities staff were constantly passing through the dining area during meal times engaging the Residents.</p> <p>Dignity with Meals:</p> <p>Resident #4</p> <p>Observation on 4/5/16 at 8:55 am revealed CNA #2 assisted Resident #4 with his/her meal. During the observation CNA #2 used a clothing protector to wipe the Resident's mouth.</p> <p>Further observation at 9:05 am and again at 9:06 am revealed CNA #2 used a spoon to wipe Resident #4's mouth. Observation at 9:07 am and again at 9:08 am revealed CNA #2 used the Resident's clothing protector to wipe his/her mouth.</p> <p>Resident #5</p>	F 241	<p>then weekly for a month to ensure compliance with the above stated plan. Rounds will be made regularly and at least monthly after that to ensure compliance is being maintained. This will be added to the Long Term Care quality calendar. The above rounding will be restarted if a deficiency in compliance is identified.</p> <p>Starting with the next staff meeting, all staff will be receiving additional training regarding caring for residents with dementia. Also, CNAs were in-serviced on 05/05/2016 regarding how to manage resident□s who were resistant when receiving personal care. The resident who was holding onto her clothing will have her care plan updated to show that extra time needs to be taken when doing personal care to ensure she feels safe. Staff will not forcibly remove the resident□s hands from her clothing. Instead, they will look to other techniques such as distraction or by moving onto something else and revisiting the activity that the resident is resisting at a later time.</p> <p>The Director of Nursing of Long Term Care will be present for the above resident□s personal care at least once daily for five days to ensure staff are appropriately providing care to the resident and to receive in the moment education if required. She will then randomly observe personal care given to residents at least bi-monthly. This will be added to the Long Term Care Quality calendar for continued observation.</p>		

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F 241	<p>Continued From page 5</p> <p>Observation on 4/5/16 at 9:15 am revealed CNA #4 assisted Resident #5 with his/her meal. During the observation CNA #4 used a clothing protector to wipe Resident #5's mouth.</p> <p>During an interview on 4/6/16 at 9:30 am the ACNO stated staff should use a napkin to wipe a Resident's face during meals. The ACNO further stated it was not okay to use a clothing protector or spoon to wipe a Resident's mouth during meals.</p> <p>Dignity with Cares:</p> <p>Resident #4</p> <p>Observation on 4/6/16 at 11:40 am revealed CNA #'s 3 and 4 assisted Resident #4 with incontinence care. CNAs transferred Resident #4 to the Rehab room where they assisted Resident #4 to a table. During cares CNA #3 pulled down Resident #4's pants while the Resident held onto his/her pants. CNA #3 tugged the pants roughly out of Resident #4's hands.</p> <p>Privacy During Cares:</p> <p>Resident #4</p> <p>An observation on 4/6/16 at 11:43 am during cares, Activity Staff #1 came into the rehab room while Resident #4 was being assisted with incontinence care. The Activity Staff did not knock. No curtain or sheet covered the Resident during cares.</p> <p>During an interview on 4/7/16 at 10:10 am, the</p>	F 241	<p>In addition to the above training for the nursing staff, there has been a facility wide training provided on resident privacy. This will be completed by all staff by 05/23/2016.</p> <p>In regards to the shower door, the safety hinge was removed immediately so that there was no further resident privacy issue. The Director of Nursing of Long Term Care and the Maintenance Director surveyed the rest of the Long Term Care unit and no other privacy concerns were identified. The resident's will be asked at the next resident council meeting if they have any other privacy concerns. Any identified will be addressed immediately. As a long term solution, the safety hinge will be replaced and there will be weather stripping placed over the crack to ensure resident privacy as well as their safety by 05/23/2016.</p> <p>Privacy concerns will be added to the resident council meeting agenda monthly and any identified concerns will be addressed.</p>	

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F 241	Continued From page 6 CNO stated Residents should be treated as adults.  Shower Door:  During a group interview on 4/5/16 at 10:22 am, Residents #'s 1 and 3 disclosed the facility shower room door does not close all the way, leaving them exposed to people looking in as they go by in the hallway.  Observation on 4/5/16 at 12:30 pm revealed a metal hinge that was mounted to the door frame that prevented the door from shutting all the way. The opening was approximately ½" wide.  During an interview on 4/7/16 at 10:10 am the CNO stated she did not know the shower room door did not close. The ACNO stated it is not okay to leave the shower room door open. The ACON further stated if anyone can see in, the facility will address the problem.  Review of the facility's policy and procedure, "PERSONAL PRIVACY/DIGNITY," dated 12/8/08, revealed "All residents will be treated with dignity and compassion."  Review of the facility's admission packet that included the handbook titled "A Matter of RIGHTS" revealed, "Your right to be treated with dignity and respect is the foundation on which all your other residents rights and responsibilities are based."	F 241			
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		5/23/16	

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F 309 SS=D	<p>Continued From page 7 HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and interview the facility failed to follow the plan of care in the areas of: 1) bathing for 1 resident (#4); and 2) incontinence care for 2 residents (#'s 4 and 5) out of 5 sampled residents whose care plans were reviewed. These failed practices placed the residents at risk for not receiving care and services for their highest well-being.</p> <p>Findings:</p> <p>Baths:</p> <p>Resident #4</p> <p>Record review on 4/5-8/16 revealed Resident #4 had diagnoses that included cerebrovascular accident (CVA - damage to the blood vessels in the brain) with right sided paralysis and dementia.</p> <p>Review of the most recent MDS (Minimum Data Set) assessment, a quarterly assessment dated 3/15/16, revealed Resident #4 was assessed as total assist for bathing.</p> <p>Review of Resident #4's "Multi-Disciplinary Care</p>	F 309	<p>Baths: This identified resident often receives bed baths daily. However, this should not and will not be a substitution for a scheduled tub bath. Staff will receive an in-service at the next staff meeting reminding them that bed baths are not appropriate substitutions for a tub bath or shower. Residents are assessed on a quarterly basis and PRN to ensure that their bathing needs are still being met and appropriate for their care. Care plans will be updated accordingly. Bathing schedules will be monitored regularly by the Director of Nursing of Long Term Care.</p> <p>Incontinence Care: Based on the resident's care plans, a check list will be created for the identified residents and any others as appropriate. Completion and compliance will be monitored by the Director of Nursing of Long Term Care (LTC) and added to the LTC quality calendar. Also, a bowel and bladder program is being started by the</p>		

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F 309	<p>Continued From page 8</p> <p>Plan," dated 3/30/16 revealed under the "PROBLEM Potential alteration in skin integrity related to decreased mobility and incontinence...APPROACH...[Resident's Name] is scheduled for a bath twice weekly and as needed...is dependent for transfers into the tub as well as dependent for the bathing activity."</p> <p>Observation on 4/5/16 at 6:15 am, revealed Resident #4 was dressed and up in his/her wheelchair.</p> <p>During an interview on 4/5/16 at 6:30 am, when asked about morning cares and Resident #4's bath schedule, CNA #3 stated Resident #4 was up early today. CNA #3 further stated, Resident #4 was assisted with a bed bath this morning before s/he got up and would not be getting a tub bath.</p> <p>During an interview on 4/6/16 at 9:30 am, the Assitant Chief Nursing Officer (ACNO) stated, the expectation is if a Resident is supposed to have a tub bath then a bed bath would not be given.</p> <p>Record review on 4/8/16 of the facility's policy "CNA DUTIES," revised 5/4/09, revealed "CNA DUTIES...0915 Scheduled baths..."</p> <p>Incontinence Care:</p> <p>Resident #4</p> <p>Observation on 4/5/16 at 6:15 am revealed Resident #4 in the dining room, dressed and in his/her wheelchair.</p> <p>During an interview at 6:31 am, CNA #3 stated Resident #4 would be assisted for incontinence</p>	F 309	Restorative Aide beginning the week of May 15, 2016.		

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F 309	<p>Continued From page 9 care between 7:30 am and 7:40 am.</p> <p>Further observation on 4/5/16 from 6:16 am - 9:30 am revealed Resident #4 in the dining room in his/her wheelchair. The Resident was not assisted to the bathroom for incontinence care during this time, or repositioned in the wheelchair.</p> <p>Record review on 4/5-7/16 of Resident #4's "Multi-Disciplinary Care Plan," dated 3/30/16 revealed under the "PROBLEM Self care deficit: toileting related to decreased mobility and confusion...APPROACH...[Resident's Name] wears depends for incontinence. Change depends every 2 hours and with incontinent episodes."</p> <p>Review of the "ADL [Activities of Daily Living] Report," (the care plan used by the CNAs), for March 2016 revealed, "...Continence:...changed every 2 hours or more often for incontinence..."</p> <p>Resident #5</p> <p>Record review on 4/5-7/16 revealed Resident #5 was admitted to the facility with diagnoses that included advanced dementia.</p> <p>During a continuous observation on 4/5/16 from 7:00 am-9:45am revealed Resident #5 in the dining room sitting in his/her wheelchair. The Resident was not assisted to the bathroom for incontinence care during this time or repositioned in the wheelchair.</p> <p>During an additional continuous observation on 4/6/16 from 6:20 am-10:00am revealed Resident #5 in the dining room sitting in his/her wheelchair. The Resident was not assisted to the bathroom</p>	F 309			

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F 309	Continued From page 10 for incontinence care during this time or repositioned in the wheelchair.  Record review on 4/5-7/16 of Resident #5's "Initial Interdisciplinary Care Plan," dated 3/15/16, revealed under "Problem/Need Incontinent of[check] Bladder...Interventions...[check]Check at least every 2 hours, wash, rinse and dry soiled areas and change clothes PRN (as necessary) after each incontinence episode... [check]Encourage resident to use the bathroom facilities before and after meals...[check]Resident bathroom facilities used are:[toilet]."  During an interview on 4/7/16 at 10:30 am, the ADON stated she was unaware that dependent Residents were not assisted for incontinence care every 2 hours.	F 309			
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION  Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  This REQUIREMENT is not met as evidenced by: . Based on record review, observations and interview the facility failed to provide appropriate treatment and services to increase range of	F 318	A Restorative Aide had been hired prior to the survey and will begin working in that role prior to May 23, 2016. With the assistance of the therapy departments,	5/23/16	

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F 318	<p>Continued From page 11</p> <p>motion and/or to prevent the decrease in range of motion for 4 residents with contractures. Specifically, the facility failed to ensure: 1) a splint provided by therapy was used as indicated for 1 resident (#1) out of 2 sampled residents with splints; and 2) range of motion exercises were provided by the facility for 1 sampled resident (#4) out of 5 Residents who were identified by the facility with contractures. This placed all residents with contractures at risk for a decrease in range of motion and functional ability. Findings:</p> <p>Splint:</p> <p>Resident #1</p> <p>Record review from 4/5-7/16 revealed Resident #1 had diagnoses that included left upper extremity hemiplegia (paralysis of one side of the body) and cerebrovascular accident (CVA - damage to the blood vessels in the brain).</p> <p>Record review of the most recent quarterly "Physical Therapy Screen," dated 3/15/16, revealed the resident had impairment to an upper extremity and required occasional assistance from staff.</p> <p>Record review of most recent MDS (Minimum Data Set), a quarterly assessment dated 3/21/16, revealed the Resident was assessed for having functional limitations in an upper extremity.</p> <p>Record review of the most recent physician's progress note, dated 4/4/16, revealed the Resident had hemiplegia with a contracture to the left hand.</p> <p>Random observations from 4/4-8/16 revealed the</p>	F 318	<p>plans of care will be created and all appropriate residents will be included in the Restorative program.</p> <p>The Director of Nursing of Long Term Care will directly oversee the Restorative program. The plans of care will be reviewed monthly at the Long Term Care meeting to ensure that resident's who need restorative care are enrolled in the appropriate restorative program.</p>		

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F 318	<p>Continued From page 12</p> <p>Resident's left arm sitting in the lap. The Resident's wheelchair had a foam support located on the left wheelchair arm.</p> <p>Additional observation on 4/6/16 from 11:00 am to 11:40 am, revealed CNA (Certified Nursing Assistants) #'s 3 and 5 assisted Resident #1 with morning cares. During the observation the CNAs did not offer assistance or the use of a splint to the Resident's left hand. Additionally, the foam support of the wheelchair arm was not used. This resulted in the Resident's left hand sitting in his/her lap.</p> <p>During an interview on 4/6/16 at 2:10 pm the Occupational Therapist (OT) stated Resident #1 should be care planned to use a splint for 4 to 6 hours a day for the left hand contracture. In addition, the OT stated it was the CNA staffs' responsibility to ensure the use of the splint.</p> <p>During an interview on 4/6/16 at 2:30 pm CNA #3 stated s/he was unaware of a splint or the use of the assistive device on the left arm of the Resident's wheelchair.</p> <p>Range of Motion:</p> <p>Residents # 4</p> <p>Record review on 4/5-8/16 revealed Resident #4 had diagnoses that included CVA with right sided paralysis and dementia.</p> <p>Random observations from 4/4-8/16 revealed Residents #4 up in his/her wheelchair in the dining room with right hand and right food contractures.</p>	F 318			

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F 318	Continued From page 13  Record review on 4/5-7/16 of Resident #4's "Multi-Disciplinary Care Plan," dated 3/30/16 revealed under the "PROBLEM Impaired physical mobility related to inability to use right side extremities post CVA...DISCIPLINE PT [Physical Therapy]...APPROACH...PROM [Passive Range of Motion] to RUE [Right Upper Extremity] & RLE [Right Lower Extremity] three times per week as tolerated...DISCIPLINE CNA...Attempt to do ROM [range of motion] twice daily or as tolerated with pain."  Random observations from 4/4-8/16 revealed Resident #4 up in his/her wheelchair in the dining room with right hand and right foot contractures.  During an interview on 4/6/16 at 11:55 am, CNA #3 stated, "We use to do range of motion; now PT does it."  During an interview on 4/6/16 at 12:30 pm, the OT stated the nursing staff is responsible for the ROM. The OT further stated the facility is aware that there is a deficit in providing ROM and is working on providing a restorative aide (RA).  During an interview on 4/5/16 at 1:05 pm, the Assistant Director of Nursing confirmed ROM is not getting done and the facility is in a process of a RA program to provide the services.  The facility did not provide a policy and procedure for range of motion prior to exit, as requested.	F 318			
F 323	483.25(h) FREE OF ACCIDENT	F 323		5/23/16	

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F 323 SS=E	<p>Continued From page 14</p> <p><b>HAZARDS/SUPERVISION/DEVICES</b></p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and interview, the facility failed to: 1) provide safety during wheelchair locomotion for 1 resident (#4) out of 2 sampled residents dependent on staff for locomotion in a wheelchair; 2) provide safe lift transferring for 1 resident (#4) out of 2 sampled residents observed during lift transfers; and 3) assess the use of seatbelts as an adaptive device for 4 residents (#s 1, 2, 4, and 5) out of 5 sampled residents reviewed with seatbelts. These failed practices placed all residents that were dependent on staff for locomotion, required a lift for transfer, and used seatbelts at risk for injury and entrapment. Findings:</p> <p>Wheelchair:</p> <p>Resident #4</p> <p>Record review on 4/5-8/16 revealed Resident #4 had diagnoses that included cerebrovascular accident (CVA - damage to the blood vessels in the brain) with right sided paralysis and dementia.</p> <p>Review of the most recent MDS (Minimum Data</p>	F 323	<p>Occupational Therapy will re-assess the identified resident for appropriateness of wheelchair fit. Any necessary changes will be made prior to 5/23/2016. All residents who use wheelchairs will receive quarterly and PRN wheelchair assessments to ensure the wheelchair is appropriate and still meeting the needs of the resident.</p> <p>Nursing staff will be re-educated on proper Hoyer transfers at the next staff meeting prior to 5/23/2016. The Chief Nursing Officer (CNO) will perform random, regular spot checks to ensure compliance.</p> <p>All residents currently using a safety belt will be re-evaluated for appropriateness and safety. The facility will ensure that all residents who are currently using a safety belt have a current device evaluation form on file. Also, the facility will ensure that a device evaluation form is completed prior to the initial use of residents going forward. New consents will be obtained at the initiation, at least annually, and with</p>		

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F 323	<p>Continued From page 15</p> <p>Set) assessment, a quarterly assessment dated 3/15/16, revealed Resident #4 was assessed as needing total assist for transfer and locomotion on and off the unit.</p> <p>Record review on 4/5-7/16 of Resident #4's "Multi-Disciplinary Care Plan," dated 3/30/16 revealed under the "PROBLEM Impaired physical mobility related to inability to use right side extremities post CVA...APPROACH...Make sure [Resident's Name] extremities are placed carefully...while in the wheelchair to prevent injury."</p> <p>During an observation on 4/6/16 at 8:35 am, Resident #4 was sitting in his/her wheelchair in the hall by the medication cart. Resident #4's feet were extended over the end of the wheelchair foot support. The right foot was bare; except for a foam heel protector that covered the heel to the middle of the foot. The toes were exposed. Further observation revealed LN #1 moved Resident #4 toward the patio door. During the movement, Resident #4's right foot hit the metal base of a rolling desk chair in the hallway.</p> <p>During an observation of care provided on 4/6/16 at 11:45 am, Certified Nursing Aide (CNA) #3 stated, "I think [s/he] needs another chair."</p> <p>During an interview on 4/6/16 at 12:20 pm, CNA #3 stated s/he told Physical Therapy (PT) back in November that Resident #4 was not sitting in the wheelchair right.</p> <p>During an interview on 4/6/16 at 12:30 pm the Occupational Therapist (OT) stated the white pad (synthetic sheepskin) and lift pad that was in place in the wheelchair were a concern because</p>	F 323	any significant changes. The DON of LTC or designee will monitor this regularly for compliance.		

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F 323	<p>Continued From page 16</p> <p>they caused the Resident to not fit in the chair properly and caused the Resident to slip.</p> <p>Lift Transfer:</p> <p>Resident #4</p> <p>Observation during cares on 4/6/16 at 11:40 am - 11:55 am, revealed CNA #'s (3 and 4) transferred Resident #4 using a mechanical lift with a sling. During the transfer, CNA #3 stood behind the wheelchair and CNA #4 stood behind the lift near the controls. Neither CNA was within reach of the Resident during the transfer.</p> <p>During an interview on 4/6/16 at 1:00 pm the Assistant Chief Nursing Officer (ACNO) stated hands should be on the Resident at all times during the transfer.</p> <p>Review on 4/13/16 of the website: <a href="http://www.fda.gov">http://www.fda.gov</a> &lt;<a href="http://www.fda.gov">http://www.fda.gov</a>&gt; revealed, "These medical devices [lifts] provide many benefits, including reduced risk of injury to patients and caregivers when properly used. However, improper use of patient lifts can pose significant public health risks. Patient falls from these devices have resulted in severe patient injuries including head traumas, fractures, and deaths."</p> <p>Seatbelts:</p> <p>Resident #1</p> <p>Record review from 4/4-7/16 revealed Resident #1 had diagnoses that included left upper</p>	F 323			

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F 323	<p>Continued From page 17</p> <p>extremity hemiplegia (paralysis of one side of the body) and CVA.</p> <p>Record review of most recent MDS (Minimum Data Set), a quarterly assessment dated 3/21/16, revealed the Resident was assessed for having functional limitations in range of motion in an upper extremity and required extensive assistance with bed mobility, transfer, dressing, toilet use, personal hygiene and bathing.</p> <p>Record review of the Resident's Care Plan, updated 3/30/16, revealed the Resident had impaired mobility due to previous CVA. Further review revealed the Care Plan stated the Resident was at high risk for falls. Interventions for the Resident included "Alarm belt on while [Resident #1] is in the wheelchair...This alerts staff if [she/he] tries to get up without assistance."</p> <p>Random observations during 4/4-7/16 revealed Resident #1 had a seat belt attached to his/her wheelchair.</p> <p>Resident #4</p> <p>Review of the most recent MDS assessment, a quarterly assessment dated 3/15/16, revealed Resident #4 was assessed as severely impaired in daily decisions.</p> <p>Review of the ADL Report for March 2016 (part of the care plan) revealed under "Positioning ...Velcro alarm seat belt used while in wheelchair resident may remove belt..."</p> <p>Random observations during 4/4-7/16 revealed Resident #4 had a seatbelt with a tab alarm</p>	F 323			

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F 323	<p>Continued From page 18</p> <p>attached to his/her wheelchair. Resident #4 occasionally pulled on the seatbelt that was closed with Velcro. When the seatbelt was released, an alarm would sound. Staff would promptly reattach the Velcro of the seatbelt.</p> <p>Resident #5</p> <p>Record review on 4/5-8/16 revealed Resident #5 had diagnoses that included Alzheimer's dementia and hip fracture.</p> <p>Review of the MDS assessment dated 3/22/16 revealed Resident #5 was assessed as severely impaired in decision making.</p> <p>During a continuous observation on 4/5/16 from 7:00 am to 10:00 am in the dining room, Resident #5 sitting was in his/her wheelchair. The Residents seatbelt was loosely fastened. The seatbelt was resting on Resident #5's upper thighs. There was a hands width space between the Resident's body and the seatbelt. During this observation at 8:50 am, Resident #5 was observed pulling on his/her seatbelt unable to unhook the clasp.</p> <p>Observation of the dining room on 4/5/16 at 2:00 pm revealed Resident #5 was very active and slid down in the recliner. Further observation revealed a latched blue seat belt device was loosely around the Resident's upper abdomen.</p> <p>An additional observation on 4/6/16 from 6:20 am to 10:00 am in the activity room revealed, Resident #5 sitting in his/her wheelchair. The Resident's seatbelt was loosely fastened and resting on his/her thighs while asleep and leaning</p>	F 323			

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F 323	<p>Continued From page 19 to the right side of his/her wheelchair.</p> <p>During an interview on 4/5/16 at 3:00 pm, when asked for a copy of the seatbelt assessments, the ACNO stated no assessments were done for seatbelts since they are not a restraint. The ACNO further stated no risk and benefits consents were needed since the Residents were able to remove the seatbelts. When asked why the seatbelt was used for Residents #'s 4 and 5, the ACNO stated they were used for abrupt position changes.</p> <p>During an interview on 4/6/16 at 12:30 pm, the OT stated the seatbelts used for Residents #'s 4 and 5 were used as alarms so that the Resident would not fall out of the chairs.</p> <p>Review on 4/8/16 of the facility's policy titled "SEATBELTS WITH ALARMS," dated May 2006 revealed, "The belt should not be tight, allow adequate room for the resident to be comfortable...Any resident using the belt must be able to undo the belt by themselves."</p> <p>Review on 4/8/16 of the facility's policy titled "PHYSICAL RESTRATINTS/DEVICE ASSESSMENT," with the last revision date of 2/09 revealed, "...A device evaluation form will be completed on every resident, which will be used to determine if a device is a restraint...The device evaluation form will be...reviewed quarterly.</p> <p>Review of the facility's policy titled "PHYSICAL THERAPY ASSESSMENT," undated and with no signature, revealed, "Residents being admitted to the facility will be assessed for their physical wellbeing and safety concerns by the physical therapist. Assessments will be done on</p>	F 323			

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F 323	Continued From page 20 admission, annually, quarterly and PRN [as needed]."	F 323			
F 333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and interview the facility failed to ensure a medication was administered as prescribed by the physician for 1 resident (#4) of 4 sampled residents for which medications were observed. Specifically, an incorrect dose of a medication was administered. This failed practice resulted in a significant medication error that placed the resident at risk for injury and harm. Findings:</p> <p>Review of Resident #4's medical record on 4/5-7/16 revealed the Resident had diagnoses that included hyperkalemia (elevated potassium in the blood) and chronic kidney disease (disease which can affect sodium and potassium levels in the blood).</p> <p>Review of the medication administration record on 4/6/16 at 8:30 am revealed an order for "Kayexalate 15 gm [every] 3 days oral in juice." Examination of the bottle of Kayexalate revealed a pharmacy label which had the information "Kayexalate 15 gm," the manufacturer's</p>	F 333	<p>Nurse was interviewed and states that she was distracted during the administration process. Medication error report was filled out and resident's physician was notified of the error. No new orders were received. No apparent adverse effects due to the medication error. The nurse has been re-educated on the administration process and specific education also was given on the medication in question. All nurses will receive similar education prior to 05/23/2016 outlining the medication administration process with emphasis placed on following the manufacturer's recommendations in collaboration with the physician's orders. The Director of Nursing of Long Term Care or designee will continue to perform random medication pass observations at least twice monthly. This is on the Long Term Care Quality Calendar.</p>	5/23/16	

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F 333	<p>Continued From page 21</p> <p>instructions on the side of the bottle revealed "15 gm equal 4 level teaspoons approximately."</p> <p>Review of the physician's orders, dated 3/28/16, revealed an order for "Kayexalate...15 GM [every] 3 days ORAL DX: [diagnosis] Hyperkalemia."</p> <p>During an observation of a medication pass on 4/6/16 at 8:30 am LN #1 prepared to give Resident # 4 the oral medication Kayexalate (a medication given to lower potassium levels in the blood). LN #1 used a plastic teaspoon to place 3 scoops the powdered medication into a plastic medication cup, filling it to the 15 cc (cubic centimeter - unit of volume measurement) line.</p> <p>During an interview on 4/6/16 at 8:31 am LN #1 was asked how he/she calculated the amount to administer to Resident #4. LN #1 stated he/she used a cellular phone to convert the dosage, "It's a 1 to 1 conversion." When the surveyor pointed out the manufacturer's instructions on the side of the bottle the LN stated "it says approximately 4 teaspoons." LN #1 then recalculated the dosage on his/her cellular phone and then proceeded to administer the 15cc (3 teaspoons) of Kayexalate to Resident #4.</p> <p>During an interview on 4/7/16 at 2:15 pm, the Pharmacist was asked how much medication was to be administered to Residents #4 per the current Kayexalate order. The Pharmacist stated Kayexalate 15 gm is approximately 20 cc total in a plastic medicine cup. The Pharmacist confirmed the dose given on 4/6/16 at 8:30 am medication pass of 15 cc (3 teaspoons) is 5cc less the ordered 15 gm.</p> <p>During an interview on 4/7/16 at 3:30 pm the</p>	F 333			

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F 333	Continued From page 22 Assistant Chief Nursing Officer (ACNO) confirmed the correct dose of Kayexalate 15 gm is 20 cc approximately 4 teaspoons and LN #1 administered the incorrect dose.  Review of the Resident's lab results revealed the following potassium levels (normal ranges Low 3.5 mmol/L - High 5.1 mmol/L): · 3/8/16 - potassium level was 4.2 mmol/L; · 3/22/16 - potassium level was 4.4 mmol/L; · 3/29/16 - potassium level was 4.6 mmol/L; and · 4/5/16 - potassium level was 5.1 mmol/L (a 0.9 increase from the 4 weeks).  According to Medicine net, accessed 4/14/16 at < <a href="http://www.medicinenet.com/hyperkalemia/article.htm">http://www.medicinenet.com/hyperkalemia/article.htm</a> >, revealed "Extremely high levels of potassium in the blood (severe hyperkalemia) can lead to cardiac arrest and death....when not recognized and treated properly, severe hyperkalemia results in a high mortality rate. Normal blood levels of potassium are critical for maintaining normal heart electrical rhythm..." high blood potassium levels (hyperkalemia) can lead to abnormal heart rhythms."	F 333			
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON  Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.  Except when waived under paragraph (c) or (d) of this section, the facility must designate a	F 354		5/23/16	

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F 354	<p>Continued From page 23</p> <p>registered nurse to serve as the director of nursing on a full time basis.</p> <p>The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>.</p> <p>Based on observation, interview, and record review the facility failed to provide a Director of Nursing (DON) for at least 35 hours/week. This failed practice placed all residents,(based on a census of 14), at risk of harm by not having required Director of Nursing supervisor level monitoring of care practices devoted to long-term care specifically for 35 hours/week. Findings:</p> <p>Throughout the 4/4-8/16 survey the Assistant Chief Nursing Officer (ACNO) was observed working as the Long Term Care Clinical Manager full time. The CNO worked both as the acute care DON and supervised the ACNO.</p> <p>During an interview on 4/7/16 at 4:00 pm am the CNO stated she worked over 40 hours a week for the Critical Assess Hospital and LTC.</p> <p>During an interview on 4/8/16 at 7:50 am, the Administrator confirmed the job description did not specify that the CNO worked at least 35 hours for the LTC unit.</p> <p>Record review on 4/7/16 of the Chief Nursing Officer Job Description provided by the facility revealed, "The Chief Nursing Officer (CNO) has</p>	F 354	<p>A member of the nursing administration team had been functioning as the manager of Long Term Care. However, her title and job description have now been updated to reflect the title of: Director of Nursing of Long Term Care. This title change was done during the survey process. The job description will be updated to meet the requirement regarding the need for a DON of Long Term Care. It is possible that the residents may have not known who to contact if they had any concerns so, At the next resident council meeting, the residents will be informed of the title change to Director of Nursing of Long Term Care and her respective job duties.</p>		

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F 354	Continued From page 24 overall nursing responsibility for the Critical Access Hospital (CAH) and has dual responsibility for the Long Term Care (LTC)."	F 354			
F 363 SS=F	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED  Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.  This REQUIREMENT is not met as evidenced by: . Based on observation, record review and interview the facility failed to prepare meals according to planned menus authorized by a qualified dietitian. This failure resulted in the preparation of nutritionally inadequate meals that had the potential to affect all residents (based on a census of 14) who received food and beverages from the food service department. Findings:  During an observation of lunch preparation on 4/6/16 at 12:27 pm revealed Cook #1 spooning white rice onto plates.  Record review on 4/6/16 of the dietary lunch menu for that day revealed the lunch meal would include baked fish, tartar sauce, brown rice, milk and chocolate chip cookie.  During an interview on 4/6/16 at 12:50 pm Cook	F 363	All residents were potentially affected by the menu being changed without prior approval. No direct adverse events took place, but there is the potential that an adverse event could occur. The dietary staff will be in-serviced on the food substitution policy with emphasis on the fact that only the Support Services Director and the Registered Dietician have the authority to change the menu, prior to 05/23/2016. The Support Services Director will monitor for compliance weekly for the first month, then at least monthly thereafter, and address any educational needs PRN. This will be added to the Support Services Quality Calendar.	5/23/16	

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F 363	Continued From page 25 #1 was asked why brown rice was not served with the lunch meal. In response, Cook #1 stated she didn't want to prepare brown rice that day.  Record review of the Resident Council Meeting minutes, dated 3/1/16, revealed the Residents wanted more brown rice. Further review revealed the Dietary Manager noted the facility would occasionally provide brown rice.  During an interview on 4/7/16 at 4:43 pm the Registered Dietitian (RD) stated only the Dietary Manager and the RD could make changes to the preapproved menu established by the RD. In addition, the RD stated the Cook should not have replaced the brown rice without prior authorization. The RD continued to state white rice does not contain the same amount of fiber as the brown rice.  Review of the facility's policy "MENU SUBSTITUTIONS," dated 2/2005, revealed "Cooks in the Dietary Department must prepare the food as stated on the menu. Menus are not to be changed, except by the Support Services Director's orders."	F 363			
F 365 SS=E	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS  Each resident receives and the facility provides food prepared in a form designed to meet individual needs.  This REQUIREMENT is not met as evidenced by:	F 365		5/23/16	

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F 365	<p>Continued From page 26</p> <p>Based on record review, observation and interview the facility failed to ensure the correct consistency of food/drink, per residents' needs, were provided for 3 resident's (#4, 5, and 6) out of 8 sampled residents. Failure to prepare food/drink in the required form placed the resident's at risk for aspiration, and/or weight loss and had the potential to negatively affect the resident's enjoyment of dining. Findings:</p> <p>Resident #4</p> <p>Record review on 4/5-8/16 revealed Resident #4 had diagnoses that included diabetes mellitus, CVA (stroke) w/ left sided paralysis, dementia and dehydration.</p> <p>Review of the most recent MDS (Minimum Data Set) assessment, a quarterly assessment dated 3/15/16, revealed the Resident was assessed as needing total assistance for eating with 1 person assist.</p> <p>Further review of the physician's diet order revealed, Resident #4 had an order for fluids thickened to a nectar consistency and pureed foods.</p> <p>Observation on 4/4/16 at 5:30 pm - 6:00 pm during the dinner meal, revealed CNA #1 assisted Resident #4 with his/her meal. During the observation CNA #1 took a container of thicket (a powder added to food or liquid to thicken the consistency) on the table and sprinkled/poured it over Resident #4's food without measuring it for nectar consistency.</p> <p>Resident #5</p>	F 365	<p>For the residents who require altered thicknesses on their diets, the facility will provide pre-thickened, prepackaged liquids. In the instance something cannot be purchased pre-packaged in the appropriate thickness, the staff will use pre-measured thickening packets. . All staff will receive an in-service on the new products with assistance from the Speech Therapist. All new products will be implemented prior to 05/23/2016</p> <p>The Director of Nursing of Long Term Care will ensure random weekly checks during one of the meal times for the first month, then monthly thereafter to ensure that resident's foods that require thickening are being done appropriately. This will be added to the Long Term Care Quality Calendar.</p>		

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F 365	<p>Continued From page 27</p> <p>Record review on 4/5-7/16 revealed Resident #5 was admitted to the facility with a diagnosis of advanced dementia.</p> <p>Record review on 4/5-7/16 revealed Resident #5 had an order for pureed diet with honey thick liquids.</p> <p>Record review of Resident #5's Admission History &amp; Physical Examination, dated 3/15/16, revealed the Resident had a history of aspiration pneumonia and to continue the "[pureed diet and honey thick liquids] to prevent any further aspirations."</p> <p>Observation on 4/5/16 at 7:22 am, revealed CNA #3 was using a spoon to feed Resident #5 substances from cups. The substances were thick and appeared to have the consistency of firm pudding.</p> <p>During another observation on 4/6/16 at 12:45 pm in the dining room revealed, Resident #5 seated in his/her wheelchair at the table for lunch. CNA #4 brought Resident #5's tray to the table and placed the food/liquid filled dishes on the far right side of the table out of Resident #5's reach. Then CNA #4 used a spoon to feed the Resident a thick yellow liquid from a small glass.</p> <p>During an interview on 4/6/16 at 12:45 pm CNA #4 stated the yellow liquid was thicker than pudding. The CNA further stated there is always inconsistency in the thickness of liquids for this Resident.</p> <p>Resident #6</p>	F 365			

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F 365	<p>Continued From page 28</p> <p>Record review on 4/6-7/16 revealed, Resident #6 was admitted to the facility with a diagnosis of dysarthria (a condition resulting in difficulty using or controlling muscles of the mouth and tongue) and dysphagia (a condition resulting in muscles in your throat have difficulty moving food and/or liquids to your stomach that can result in choking).</p> <p>A record review on 4/6-7/16 revealed a diet order of "dysphagia pureed with nectar thick liquids."</p> <p>Review of Resident #6's care plan, dated 3/2016, revealed the problem of "[choking] due to problems with swallowing...Approaches Diet: dysphagia pureed diet nectar consistency."</p> <p>Observation on 4/4/16 from 5:30 pm - 6:00 pm revealed Resident #6 was at the dining table eating his/her dinner meal. During the observation, CNA #1 added thicket from a container on the table to Resident #6's drink, without measuring.</p> <p>During an observation on 4/5/16 at 7:25 am in the dining room, Resident #6 was seated in his/her wheelchair at the table using a spoon to scoop thick coffee out of a cup. He/she then tapped the glass on the top of the table to move the thick coffee from the bottom of the cup to the sides to scoop out more of the thickened coffee with a spoon.</p> <p>During an additional observation on 4/5/16 at 8:14 am revealed Resident #6 was at the dining table attempting to drink from a cup that contained a purple substance. When Resident #6 raised the cup up to consume the contents, the purple</p>	F 365			

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F 365	<p>Continued From page 29</p> <p>substance was thick and did not come out of the cup. Next, while holding the cup over his/her head, the Resident attempted to shake the cup several times to loosen the purple substance. After multiple failed attempts the Resident placed the cup to the side of his/her meal.</p> <p>During a group interview on 4/5/16 at 10:22 am Resident #6 stated his/her liquids are either too thin or thick and he/she had to use a spoon to scoop it out of the cup.</p> <p>During a continuous observation in the dining room on 4/6/16 from 12:30 pm to 1:15 pm revealed, Resident #6 sitting in his/her wheelchair at the table eating a meal. After taking a bite, the Resident moved his/her wheelchair toward the middle of dining room as he/she began forcefully coughing, rocking back and forth in the wheelchair while his/her face turned red.</p> <p>During an interview on 4/7/16 at 10:30 am, the Assitant Chief Nursing Officer confirmed staff should use accurate measurement to thicken fluids.</p> <p>During an interview on 4/7/16 at 4:42 pm the Registered Dietitian (RD) stated she had provided multiple training opportunities to staff on the proper method of using the thickening powder. The RD further stated the staff should measure the thickening powder per manufacturer's instructions.</p>	F 365			
F 368 SS=F	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME	F 368		5/23/16	

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F 368	<p>Continued From page 30</p> <p>Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.</p> <p>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>.</p> <p>Based on interview, observation and record review the facility failed to ensure: 1) no more than 14 hours were between an evening meal and breakfast the following day; and 2) substantial bedtime snacks were offered to all residents in the facility. These failed practices affected all residents living in the facility (based on a census of 14) and placed the residents at risk for undernourishment, weight loss, and impaired enjoyment of life by not meeting basic human needs. Findings:</p> <p>Meal times:</p> <p>During an interview on 4/4/16 at 4:00 pm, Cook #2 stated the breakfast is served at 8:30 am,</p>	F 368	<p>CNA staff will receive an in-service regarding the necessity of residents being offered snacks prior to going to sleep in the evenings. This in-service will also include education on using the key on the dietary forms and how to document residents intake or refusals appropriately. A substantial evening snack will be offered to every resident prior to them lying down in the evening, but after the evening meal.</p> <p>Residents will be asked monthly at the Resident Council meeting about snacks and if there are any issues with them being offered their evening snacks prior to bedtime. Any concerns or questions will be addressed appropriately. Also, the Director of Nursing of Long Term</p>		

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F 368	<p>Continued From page 31</p> <p>lunch is at 12:30 pm and dinner is served at 5:30 pm.</p> <p>Random observations from 4/4-7/16 revealed meals were served at 8:30 am, 12:30 pm and 5:30pm.</p> <p>Review of the facility's policy "Frequency of Meals," dated 2/2005 revealed, "There will be three meals served each day at fixed and regularly scheduled hours. There will not be more than 14 hours between the substantial evening nourishment and the following morning's breakfast ...Meal Times: Breakfast 8:30 am Lunch 12:30 pm Dinner 5:00 pm..." Handwritten on the page of the policy reads; "Dinner 5:30 [pm]."</p> <p>HS Snack:</p> <p>Observation on 4/5/16 at 7:30 am of the refrigerator in the dining room revealed, multiple sandwiches dated 4/4/16. The sandwiches were cut in quarters. The sandwiches included 4 burgers, and 1 tuna on white bread.</p> <p>During a group interview on 4/5/16 at 10:22 am Resident #'s 1 and 3 stated they were not offered bedtime snacks at night. The residents further stated they had to ask for a snack if they were hungry and all that was given was a quarter of a sandwich.</p> <p>During an interview on 4/7/16 at 10:15 am, the Assistant Chief Nursing Officer (ACNO) stated snacks should be offered to all Residents between 7:00 pm - 9:00 pm and Residents should be able to have a snack whenever they want.</p>	F 368	Care will review the dietary sheets on a weekly basis for four weeks to ensure that the residents are being offered their snacks and being documented appropriately. They will be monitored on a monthly basis after that and this will be added to the Long Term Care Quality Calendar.		

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F 368	Continued From page 32  During an interview on 4/7/16 at 4:42 pm the Registered Dietician (RD) stated the facility should offer a substantial snack to each Resident in the evenings. In addition, the RD stated quarter sandwiches were not a substantial snack and the facility should be offering at least a half of sandwich.  Review on 4/7/16 of the facility's policy "Frequency of Meals," dated 2/2005, revealed "...An HS snack is offered every evening. This includes protein such as milk...and a complex carbohydrate such as bread ...etc...Evening snack 8:00 pm."  Review on 4/7/16 of the facility's policy "IN-BETWEEN MEAL AND BEDTIME NOURISHMENT," dated 2/2005, revealed "...In-between meal and bedtime nourishments...and served at the appropriate time by the nursing staff...The bedtime nourishment is offered nightly to all patients and contains complex carbohydrates and protein..."	F 368			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		5/23/16	

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F 371	Continued From page 33  This REQUIREMENT is not met as evidenced by: · Based on observation, interview and policy review the facility failed to ensure: 1) a toaster was free from excessive debris accumulation in the main kitchen; 2) dry and frozen food items were discarded after the expiration of the best-by dates; 3) temperatures in a refrigerator promoted safe storage of food items; 5) a staff maintain his/her hair in a manner to prevent contamination of food; and 6) safe and sanitary practices were implemented during dishwashing. This failed practice placed all residents (based on a census of 14), receiving food from the facility at risk for food borne illnesses. Findings:  Main Kitchen:  During the initial tour of the facility's main kitchen on 4/4/16 at 4:05 pm, the following concerns were noted: · Significant accumulation of bread crumb debris in the toaster; · 1-package of Morning Star Chicken Patties with best by date 2/16/16; · 1-Kraft Thousand Island dressing with used by date 3/20/16; · 3- 1.5 quart Dryer Slow Churned Neapolitan ice cream with best by date 3/11/16 · 1- 1.5 quart of coffee flavored ice cream with	F 371	Main Kitchen: The toaster tray was emptied shortly after the crumbs were discovered. The kitchen will empty the toaster tray daily. The Support Services Director will monitor this regularly for compliance. This will be added to the Support Services Quality Calendar. A review was done of the kitchen to ensure that no other outdated items were present. The kitchen will review their process for monitoring products for outdates. The Support Services Director will re-educate staff as appropriate prior to 05/23/2016. This will continued to be monitored on the Support Services Quality Calendar.  Refrigerator Temperature: The refrigerator in question was removed from service during the survey. A new refrigerator has been purchased and now put into use. The temperature log will be reviewed and updated as necessary. By 5/23/16, the Dietary staff will receive an in-service and be re-educated on the use of the temperature log. The Support Services Director will continue to monitor the refrigerator temperature regularly on the Support Services Quality Calendar.  Food Service: The concern was addressed immediately upon survey exit and also staff were re-educated during the staff meeting on		

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F 371	<p>Continued From page 34 best by date 12/16/15; and</p> <ul style="list-style-type: none"> <li>1-1.5 quart Stone Ridge Rainbow ice cream open to air with ice crystal formation</li> </ul> <p>Refrigerator Temperature:</p> <p>Observations on 4/4-7/16 at 4:30 pm revealed a refrigerator located in the central supply room. The external thermometer indicated the internal temperature was 44 degrees Fahrenheit (F). Further observation revealed the refrigerator contained four large containers of Greek yogurt, multiple small containers of flavored yogurt, one block of American cheese, large jar of relish, 3 tubs of Gold N'Soft butter, raw carrots, 3 cantaloupe, 2 cauliflower, 2 heads of cabbage, 3 lemons, 8 rolls of crescent rolls and one bunch of celery.</p> <p>During an interview on 4/4/16 at 4:30 pm the Dietary Manager (DM) was asked by the Surveyor what the process was for checking temperatures in the refrigerator. The DM stated when the cooks come on shift; they were to document the temperature of each unit. When asked what the current temperature reading was for the secondary refrigerator located in the central supply room, the DM stated 42 or 43 degrees.</p> <p>Review of the temperature log on 4/4/16 at 4:30 pm revealed the facility was documenting either 39 or 40 degrees F each shift.</p> <p>An observation on 4/5/16 at 12:15 pm revealed the refrigerator located in the central supply room external thermometer read 45 degrees F.</p>	F 371	<p>04/21/2016 to keep long hair up when assisting residents with their meals or performing resident care. The DON of LTC will do random checks for compliance. This will be added to the Long Term Care Quality Calendar.</p> <p>Staff will receive an in-service on infection control protocols regarding dishwashing and the appropriate infection control protocols by the Infection Control RN and the Dietary Manager prior to 05/23/2016. The Support Services Director will monitor regularly for compliance with appropriate dishwashing protocols. This will be added to the Support Services Quality Calendar.</p>		

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F 371	Continued From page 35  During an interview on 4/5/16 at 12:15 pm, the Maintenance Director was asked by the Surveyor to provide the temperature reading. The Maintenance Director stated the external thermometer displayed an internal temperature of 45 degrees; the internal thermometer displayed 44 degrees.  During an interview on 4/5/16 at 12:46 pm, the DM stated the external thermometer was reading 42-44 degrees F. The DM stated the internal thermometer displayed a temperature of 43 degrees F.  During an observation on 4/5/16 at 1:23 pm the DM took internal temperatures of food items in the refrigerator. The DM stated a small container yogurt was 45 degrees F and the large jar of relish was reading 43 degrees F. The DM expressed no concern over internal food temperatures at that time.  During an interview on 4/5/16 at 2:35 pm the facility's Administrator was informed of the finding. The Administrator stated the Department of Environmental Conservation noted potential concerns regarding the temperature of the refrigerator at the end of last year (2015). The Administrator added at this time no replacement for the unit had been ordered.  An observation on 4/6/16 at 6:30 am revealed the refrigerator was still in-use and contained the same food items as the prior two days.  During an interview on 4/6/16 at 6:30 am Cook #1 was asked to provide temperature readings for the refrigerator. Cook #1 stated the external	F 371			

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F 371	<p>Continued From page 36</p> <p>thermometer indicated the refrigerator was at 44 degrees F. When Cook #1 opened the unit, he/she saw an internal thermometer and stated he/she was unaware the refrigerator contained an internal thermometer. The Cook stated the internal thermometer indicated the temperature was 44 degrees F, he/she added that temperature was not acceptable and should be no more than 40 degrees F.</p> <p>A second observation on 4/6/16 at 10:05 am revealed the refrigerator was still in-use and contained the same food items at 45 degrees F. The Administrator was made aware of the temperature again by the State Survey Agency. The facility corrected the concern only after Surveyor intervention.</p> <p>Review of the facility's policy "FOOD STORAGE," dated 12/10/10, revealed "All refrigerator...temperatures will be checked and recorded daily in the morning and evening...refrigerators will be at 35 degrees to 40 degrees Fahrenheit...Any irregularities in temperature or functions will be immediately reported to the Support Services Director."</p> <p>Food Service:</p> <p>Record review on 4/5-8/16 revealed Resident #4 had diagnoses that included diabetes mellitus, CVA (stroke) w/ left sided paralysis, and dementia.</p> <p>Review of the most recent MDS (Minimum Data Set) assessment, a quarterly assessment dated 3/15/16, revealed the Resident was assessed as needing total assist for eating with 1 person</p>	F 371			

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F 371	Continued From page 37 assist.  Observation on 4/5/16 at 8:35 am revealed CNA #2 assisting Resident #4 with his/her breakfast meal. During the observation, CNA #2's long hair that was not tied back fell forward into Resident #4's food.  Dishwashing:  Observation on 4/6/16 at 1:10 pm revealed Kitchen Staff (KS) #1 loaded dirty dishes into a tray and placed them into the dishwasher unit. After the completion of the sanitation and washing of the soiled dishes, KS #1 loaded another tray of dirty dishes and used the loaded tray to push the freshly cleaned dishes out of the dishwashing unit. During this transfer large soiled pans sticking out of the dirty tray came into contact with utensils and dishes on the clean tray.  During an interview on 4/6/16 the DM stated the observation in the dishwashing room was not acceptable practice.	F 371			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		5/23/16	

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F 431	<p>Continued From page 38</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: .</p> <p>Based on observation and interview the facility failed to ensure medication storage bottles displayed an expiration date. This failed practice placed 3 residents (#s 3, 4 and 10) at risk for receiving expired medications (based on a census of 14). Findings:</p> <p>Resident #10:</p> <p>Record review on 4/6/16 at 8:00 am revealed the</p>	F 431	<p>The identified resident's were not adversely effected by the medication labels not containing expiration dates as it was the pharmacy's policy that their medications are good for one year from the date they were filled and all of the identified medications had been filled in the prior 90 days.</p> <p>All other medications were checked to ensure they either had an expiration date printed on the label or they were not</p>		

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F 431	<p>Continued From page 39</p> <p>Resident's drug regimen included: omeprazole (decreases stomach acid), hydroxyurea (treatment of chronic leukemia, some skin cancers and ovarian cancer), aspirin, carvedilol (treats heart failure and blood pressure), and sertraline (antidepressant).</p> <p>During an observation of a medication pass on 4/6/16 at 8:00 am, LN #1 prepared 5 medications for Resident #10. All 5 pharmacy medication labels did not display expiration dates.</p> <p>During an interview on 4/6/16 at 8:00 am LN #1 was asked about the expiration date of the medications. LN #1 stated the medications are good for a year from the date on the pharmacy label when it was filled.</p> <p>Resident #4:</p> <p>Record review on 4/6/16 at 8:30 am revealed the Resident's drug regimen included: clopidogrel (anticoagulant), amlodipine (lowers blood pressure), hydralazine (blood pressure medication), metoprolol (blood pressure medication), Nexium (reduces stomach acid), Kayexalate (treats high levels of potassium in the blood).</p> <p>During an observation of a medication pass on 4/6/16 at 8:30 am, LN #1 prepared 6 oral medications for Resident #4. Observation of the medication bottles revealed all 6 prescription medication labels did not display expiration dates.</p> <p>Resident #3:</p> <p>Record review on 4/7/16 at 8:00 am revealed the Resident's drug regimen included: clopidogrel,</p>	F 431	<p>greater than 1 year from the fill date on the label if they came from the identified pharmacy.</p> <p>The distributing outside pharmacy has agreed to accommodate our request and begin printing expiration dates on all of their medication packages. This will be in effect by 05/23/2016.</p> <p>The Pharmacy RN will ensure that all future medication labels have the drug expiration date printed directly on the label. This will be monitored by the Pharmacy RN when drugs are checked into the hospital drug room. Any deficiencies will be addressed immediately with the distributing pharmacy. The Pharmacy RN will add this to the Pharmacy Quality Calendar and will report the findings during the LTC Quality Meeting monthly.</p>		

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F 431	Continued From page 40 omeprazole, aspirin, levothyroxine (thyroid hormone replacement), metformin (oral diabetic medicine), and cetirizine (antihistamine).  During an observation of a medication pass on 4/7/16 at 8:00 am, LN #3 prepared 6 medications for Resident #3. The medication bottles revealed all 6 prescription medication labels did not display expiration dates.  During an interview on 4/7/16 at 8:00 am, LN #3 stated if the expiration date isn't on the label, it's a year from the [the prescription medication] fill date on the label.  Review of the U.S. Food and Drug Administration website, accessed on 4/20/16 at < <a href="http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?fr=211.137">http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?fr=211.137</a> >, revealed "To assure that a drug product meets applicable standards of identity, strength, quality, and purity at the time of use, it shall bear an expiration date..."	F 431			
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441		5/23/16	

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F 441	<p>Continued From page 41 in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>.</p> <p>Based on record review, observation and interview the facility failed to ensure: 1) multi-use patient care equipment was cleaned after use for 1 resident (#4); 2) an infection control nurse had infection prevention training; and 3) an Infection Control Risk Assessment was completed. These failed practices increased the risk for the development and transmission of disease and infection in a vulnerable population and placed all</p>	F 441	<p>All facility Glucometers were cleaned appropriately upon the exit of the surveyors. The Glucometer policy was updated prior to the survey. All nurses will be signed off on a competency by the Infection Control RN related to the proper cleaning and usage of Glucometers by 05/23/2016. The Infection Control RN will perform random checks at least bi-monthly to ensure that the Glucometer</p>		

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F 441	<p>Continued From page 42</p> <p>the residents at risk for infections (based on a census of 14 residents). Findings:</p> <p>Glucometer:</p> <p>Observation during a medication pass on 4/6/16 at 11:55 am, revealed LN #2 used a multi-use glucometer to check the blood sugar of Resident #4. After obtaining a blood sample LN #2 removed the used test strip from the glucometer and placed it back in the case then closed the lid. LN #2 did not clean the glucometer prior to placing the glucometer in the case.</p> <p>During an interview on 4/7/16 at 2:45 pm, the Infection Control RN (ICRN) stated it was the facility's policy to clean the glucometer with the purple container Sani-wipes after resident use. The ICRN further stated the glucometer should be cleaned prior to placing it back in the case.</p> <p>Review on 4/8/16 of the facility's policy, "Glucometer - One Step Sure Step", with a revision date of 10/21/10, revealed "...When to Clean the Meter...Between all patients...Clean the outside of the meter with a cloth moistened with a 10% bleach solution..."</p> <p>Review on 4/15/16 of the manufacturer's manual obtained from the ACCU-Check Inform II website at &lt;<a href="http://www.accu-checkinformii.com">http://www.accu-checkinformii.com</a>&gt; revealed, "For multiple patient use, the meter should be cleaned and disinfected between each patient use following standard precautions..."</p> <p>Infection Control Program:</p> <p>During an interview on 4/7/16 at 2:15 pm the Pharmacist said he/she attends the Infection</p>	F 441	<p>policy is being followed. Any deficiencies will be addressed immediately. This will be added to the Long Term Care Infection Control Quality Calendar.</p> <p>Prior to the survey, an Infection Control RN was hired. Resources have been obtained for her to receive additional education. A Long Term Care infection control program will be developed and an Infection Control Committee established prior to 05/23/16 and will be discussed at the next Infection Control meeting scheduled for May 17, 2016. The Long Term Care infection control program will be reviewed/reported at least quarterly at the Long Term Care Infection Control Meeting.</p>		

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F 441	Continued From page 43 control meeting if it is held when he/she is at the facility.  During an interview on 4/7/16 at 2:30 pm the Infection Control Nurse (ICRN) stated the committee consisted of the Chief Nursing Officer (CNO), Assistant Chief Nursing Officer (ACNO), a physician, medical records staff, and a pharmacist.  During the same interview the ICRN stated the committee meets quarterly with the last meeting held 9/2015. The ICRN stated she had no training in infection prevention. There had not been an Infection Control Risk Assessment (a multidisciplinary process that focuses on reducing risk from infection throughout a facility) done by the Infection Control Committee. In addition, when asked for the infection control committee minutes, the ICRN stated the facility did not have any minutes. In conclusion, the ICRN stated there was no formal infection control program.	F 441			
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment	F 520		5/23/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>025015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/08/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>WRANGELL MEDICAL CENTER LTC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>P.O. BOX 1081 WRANGELL, AK 99929</b>		
(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 520	<p>Continued From page 44</p> <p>and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>.</p> <p>Bases on interview and record review the facility failed to maintain a Quality Improvement Committee (QIC) that developed and implemented appropriate plans of action to correct quality deficiencies they had identified or should have identified. Without sufficiently identifying or adequately addressing and communicating about areas of deficient practice, systematic correction could not be achieved and maintained throughout the facility. This deficient practice placed all residents (based on a census of 14) at risk for not receiving necessary care and services. Findings:</p> <p>During an interview on 4/7/16 from 3:00 pm - 3:30 pm the Quality Assurance RN (QARN) stated the facility was working on improving their Quality Control program. The QARN stated the facility had informal weekly long term care (LTC) meetings but was unable to provide documentation that the information went to the</p>	F 520	<p>This deficiency does not relate to an individual resident but to all the residents as a whole. Prior to the survey, a Quality Assurance Coordinator was hired. A Long Term Care quality program will be developed prior to 05/23/16. The first meeting will be held 5/17/2016. Long term care quality will be reviewed/reported at least quarterly at the quality meeting.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 520	<p>Continued From page 45</p> <p>QIC. The QARN confirmed a physician, the Assistant Chief Nursing Officer, a Pharmacist and herself attended the LTC meetings.</p> <p>Additionally the QARN stated the QI committee recently started to meet monthly. The QARN stated not all the departments attended the meetings. The QARN was not able to provide the quarterly meeting schedule or agenda except for a meeting that occurred on 2/25/16.</p> <p>Review on 4/7/16 at 4:00 pm of the most recent LTC meeting agenda, revealed no documentation of performance improvement projects with action plans, follow-up, or evaluation.</p>	F 520		