STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	025037		01/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKON KUSKOKWIM ELDER'S HOME	1100 CHIEF EDDIE HOFFMAN HWY, PO BOX 528 BETHEL, AK 99559

(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	F 000		
	The following deficiencies were noted during an unannounced Medicare/Medicaid recertification survey completed on 1/11-14/16. The survey included 8 sampled residents, 3 non-sampled residents, and one closed record. State of Alaska Department of Health & Social Service Division of Health Care Services Health Facilities Licensing and Certification 4501 Business Park Blvd Ste 24, Bldg L Anchorage, AK 99503			
F 155 SS=E	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 155		2/28/16

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

Electronically Signed — 02/05/2016

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 155	Continued From page 1 This REQUIREMENT is not met as evidenced by: . Based on personnel file review and interview the facility failed to ensure 5 out of 9 staff files reviewed contained a valid updated cardiopulmonary resuscitation (CPR) certification. This failed practice placed all residents electing to have resuscitation interventions (based on a census of 15) at risk of poor performance or insufficient knowledge base from staff during a resuscitation event. Findings: During an interview on 1/13/16 Human Resources Staff #1 stated CPR certification would be under section 5 of each staff's personnel file. Review of section 5 in staff's personnel files on 1/13/16 revealed certified nursing assistant (CNA) #s 1, 3, 4, 5 and 6 did not have valid updated CPR certification cards. .	F 155	Disclaimer: Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F155 Right to refuse; formulate advance directives Corrective action for identified residents. No specific residents were identified. This Deficiency was related to nursing staff having valid CPR certification cards on file in their personal records maintained by Human Resources. Identify residents who also may be affected and corrective action for them. All nursing staff personal files were reviewed by Human Resource staff and any missing CPR certification were identified so the Director of Nursing could correct the identified problem. Records for nursing staff that actually had current CPR certification had cards placed into their Human Resource personal record. Nursing staff who need additional training to become CPR certified had the training completed and cards were placed into their records. The Director of Nursing was responsible to ensure the training was completed System changes to prevent practice from	

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F 155	Continued From page 2	F 155	reoccurring. Nursing staff were educated on the requirement to have current CPR certification. Human Resources staff were education on the requirement to report any mission CPR certifications. Human Resource staff will be responsible to implement a system to ensure all Long Term Care Nursing Staff have current CPR certification in their personal records. This system will identify staff that need recertification 60 days prior to expiration of the current CPR certification. On a monthly basis, the Human Resource staff will provide the Director of Nursing the names of nursing staff that must complete CPR recertification within 60 days to prevent the current CPR certification from expiring. The Director of Nursing will be responsible to make sure the training is completed and new cards submitted to Human Resources. Quality assurance program that will monitor to prevent reoccurring. Human Resource staff will complete an audit no later than 30 days after date of hire on all Long Term Care employees. This audit will include ensuring Nursing Staff have current CPR certifications in their file. The Director of Nursing will address any problems noted and ensure needed training is completed. On a monthly basis the Director of Nursing will report the results of the Human Resource audit and any corrective actions taken to the Quality Assurance Performance Improvement (QAPI) committee. The	

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F 155	Continued From page 3	F 155	Human Resource audits and Director of Nursing reports will continue on an ongoing basis. Date corrective action completed. All parts of this plan will be completed by 2-28-16	
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or	F 156		2/28/16

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F 156	Continued From page 4 at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the	F 156		

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F 156	Continued From page 5 physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: . Based on record review and interview the facility failed to ensure residents or designated guardians were notified in writing of their visitation rights. This failed practice placed all residents or designated guardians at risk of not being informed of the right to visit any time. Findings: Review of the facility's admission packet, revised 4/29/14, revealed no written explanation of residents or guardians visitation rights. During an interview on 1/13/16 at 12:59 pm the Administrator stated he thought the information was placed in the admission packets, but confirmed there was no written explanation of visitation rights in the admission packet. .	F 156	F156 Notice of rights, rules, services, charges Corrective action for identified residents. No specific residents were identified Identify residents who also may be affected and corrective action for them. The system changes will keep this from affecting all residents System changes to prevent practice from reoccurring. The Administrator developed a visiting policy for the facility. A copy of this policy was included in all admission packets. Notices of the visiting policy was posted in the front lobby by the sign in desk. A letter was sent to all current residents that explained the visiting policy. All facility staff were educated on the visiting policy. Education included written test questions. The Administrator/designee was responsible to ensure all facility staff completed the	

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F 156	Continued From page 6	F 156	education on visiting policy. Quality assurance program that will monitor to prevent reoccurring. The Administrator/designee will complete an audit of 5 facility randomly selected staff one time per month to see if they can correctly describe the visiting policy. The Administrator/designee will submit a report based on this audit to the QAPI committee once per month. Audits and reports will continue for 3 months and then as directed by the QAPI committee. Date corrective action completed. All parts of this plan will be completed by 2-28-16	
F 159 SS=F	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.	F 159		2/28/16

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F 159	Continued From page 7 The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: . Based on record review and interview the facility failed to ensure: 1) quarterly financial account statements were sent to residents and/or their legal representatives for 11 out of 11 residents that had trust accounts, and 2) residents were notified when their account reached $200 less than the Supplemental Security Income (SSI) resource limit for 3 residents (#s 5, 10 and 11) out of 11 residents with trust accounts. These failed	F 159	F159 Facility management of personal funds Corrective action for identified residents. Resident #5, Resident #10 and Resident #11 all had their conservator informed of the need to reduce the balance of the Resident Trust Account (RTA) to below $200 of the Supplement Security Income (SSI) resource limit.	

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F 159	Continued From page 8 practices denied consistent access to personal fund account balances and had the potential for the residents to lose eligibility for Medicaid. Findings: Trust Accounts Record review on 1/14/16 at 12:10 pm revealed Resident Trust Account statements with the date 12/31/15. There was no address on the statements to which the statements would be sent. The statements showed account balances but no activity (deposits and/or withdrawals). When asked if the statements should show account activity the Finance Administrator (FA) stated "Yes." When asked what the time period for the statement was, the FA stated it was for the period ending 11/30/15. The date of 11/30/15 was not on the statements. The facility was unable to provide any other statements. During an interview on 1/14/16 at 12:15 pm, the FA stated s/he created Resident Trust Account statements last night for the first time. The FA stated s/he worked in this position for 2 years and had never sent out statements. When asked if s/he was supposed to send out trust account statements quarterly, the FA stated, "Yes, I know that we are supposed to send them." During an interview on 1/14/16 at 7:45 am, the Long Term Care (LTC) Administrator stated the finance department " has struggled with sending them [statements]." The LTC Administrator further stated the facility needed a simpler process.	F 159	A statement showing all transactions starting from the date the account was opened was sent to all residents who have a Resident Trust Account. The 11 residents who have the facility manage personal funds for them, were mailed a RTA Statement showing all transactions since the account was opened. The statement informed the resident/conservator/responsible party how close the RTA balance was to the SSI resource limit. The Finance Administrator produced the statement and the facility Administrator was responsible ensure they were mailed or shared with the resident. Identify residents who also may be affected and corrective action for them. All residents who have accounts will be notified. System changes to prevent practice from reoccurring. The Resident Trust Account policy to manage funds was reviewed and the rules were shared with financial services. Changes in the revised system include: 1. Monthly reconciling and notifying residents/conservators/families if the RTA account is within $200 of the SSI resource limit. 2. Designating the Finance Administrator as responsible to mail the RTA statements on a quarterly basis. 3. Designating the Administrator as responsible to follow up with residents/conservators/family that are	

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F 159	Continued From page 9 During an interview on 1/14/16 at 12:25 pm, when asked for a policy and procedure related to Resident Trust Accounts, the FA stated "I have not seen any." Medicaid Account Balances Notices Record review on 1/14/16 at 12:10 pm of the Resident Trust Account statements, dated 12/31/15 showed 3 Resident's with account balances greater than the Medicaid resource limit. Resident #5's account showed a balance of $2253.81; Resident #10's account showed a balance of $2100.27; and Resident #11's account showed a balance of $2300.58. Record review on 1/14/16 of the facility's notice "Medicaid and Long-Term Care (LTC)", which was posted at the facility, stated the Medicaid LTC eligibility amount was $2130.00/month." During an interview on 1/14/16 at 12:10 pm, the Administrator stated he notified the Residents and/or their legal representatives by telephone when the Resident accounts were around $2000.00. During a subsequent interview on 1/14/16 at 2:30 pm, the Administrator confirmed he did not know the current Medicaid LTC eligibility amount, but notified Residents and/or their legal representatives when accounts were around $2000.00. During a follow up interview on 1/14/16 at 4:32 pm, the Administrator confirmed the SSI limit was around $2150.00.	F 159	within $200 of the SSI resource limit on a monthly basis. Quality assurance program that will monitor to prevent reoccurring. Each month the administrator will report to the QAPI committee the name of any residents who were sent a letter informing them that the resident□s RTA balance was within $200 of the SSI resource limit. At the end of each quarter, the Administrator will submit a report to the QAPI Committee showing that monthly statements were sent to all residents who have the facility manage personal funds for them. Both reports will continue on an ongoing basis. Date corrective action completed. All parts of this plan will be completed by 2-28-16	

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F 159	Continued From page 10 .	F 159		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: . Based on policy review the facility failed to incorporate into written policy and procedure all the components related to abuse and neglect. Specifically, the policy and procedure did not include that residents have the right to be free from misappropriation of resident property. This omission placed residents at risk for potential abuse and neglect situations and affected all residents residing in the long term care units (based on a census of 15). Findings: Review of the policy "LTC Abuse Prevention" revealed "The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." Misappropriation of resident property was not included in the potential abuse and neglect of a resident. .	F 226	F226 Develop/implement abuse/neglect, ect. policies Corrective action for identified residents. No specific residents were identified Identify residents who also may be affected and corrective action for them. The system changes will keep this from affecting all residents System changes to prevent practice from reoccurring. The facility Administrator reviewed and updated the Abuse and Neglect Prevention Policy. All facility staff were educated on the Abuse and Neglect Prevention policy. Education included written testing. The facility Administrator was responsible to ensure all facility staff completed the training Quality assurance program that will monitor to prevent reoccurring. The Administrator/designee will complete an audit of 5 facility randomly selected	2/28/16

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F 226	Continued From page 11	F 226	staff one time per month to see if they can correctly identify abuse. The Administrator/designee will submit a report based on this audit to the QAPI committee once per month. Audits and reports will continue for 3 months and then as directed by the QAPI committee. Date corrective action completed. All parts of this plan will be completed by 2-28-16	
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: . Based on record review, interview and policy review the facility failed to resolve grievances brought forth by residents who attended the Residents Council (based on the 3-4 documented number of residents who attended the meetings). As a result, residents were denied the right to have their concerns validated. Findings: Review of the Residents Council meeting minutes, on 1/13-14/16, for January-December 2015 revealed residents met 7 times with facility staff who attended the council meetings. The following grievances were documented in the	F 244	F244 Listen/Act on group grievances/recommendations Corrective action for identified residents. No specific residents were identified Identify residents who also may be affected and corrective action for them. The facility held a resident council meeting and reviewed the listed unaddressed concerns indentified in this statement to see if follow up could be completed. When possible corrective action was taken.	2/28/16

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F 244	Continued From page 12 meeting minutes: Multiple missing clothing items; Missing purse, coat, and 1 box after a resident returned from visiting family; Clothes were not being returned to the right residents; Missing key; Missing hearing aid; Missing camera; Increased noise at night outside the facility; 1 resident said he was missing 1 pair of shorts and 1 pair of pants. "No description was given so no follow up at this time."; No one was available in the evening to translate; and Multiple food concerns. Continued review of the council meeting minutes revealed no documented resolutions of any of the residents grievances listed above. During an interview on 1/12/16 at 10:00 am, the Activity Coordinator (AC) stated she gets residents' concerns/grievances from the resident's council meetings. During an interview on 1/12/16 at 1:00 pm, the AC said she was responsible for the resident's council since there wasn't a social worker. She confirmed residents have complained about missing clothing, a purse, coat, camera, in addition to other concerns. She did not do any investigations on the grievances, did not forward concerns/grievances to appropriate department heads, and did not keep a log of the residents' concerns/grievances. She did confirm there was no documented resolution of grievances/concerns in the council meeting	F 244	System changes to prevent practice from reoccurring. The facility Administrator revised the Resident Council policy to include designating the Activity Coordinator responsible to communicate any concerns/grievance to the appropriate department supervisor. A copy of the concerns will also be submitted to the facility Administrator. The Activity Coordinator or Social Worker/designee will be responsible to log grievances. All facility staff will be educated on the revised Resident Council policy to ensure that resident concerns/grievance expressed at any time are report to the appropriate department manager. Education will also include the YK corporate grievance and concern policy. Education will include written testing. Quality assurance program that will monitor to prevent reoccurring. The Administrator/designee will complete an audit of 5 facility randomly selected staff one time per month to see if they can correctly identify how to handle any resident concern/grievance. The Administrator/designee will submit a report based on this audit to the QAPI committee once per month. Audits and reports will continue for 3 months and then as directed by the QAPI committee. The Activity Coordinator or Social Worker will submit a Resident Council report to the QAPI committee showing all grievances expressed by residents during	

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F 244	Continued From page 13 minutes. The Surveyors requested a policy and procedure on grievances. They were given 2 policies with the same title, number and effective date but the policies and procedures were different. Review of the first policy given to Surveyors, "LTC [Long Term Care] Grievance Policy", dated 10/1/13, revealed "The center will actively seek resolution to concerns ...The Social Worker will log all concerns/grievances received onto the facility grievance log...The Social Worker/Designee will keep a running log of concerns voiced and their resolution as well ..." Review of the second policy given to Surveyors, "LTC Grievance Policy ", dated 10/1/13, revealed "...Concerns/grievances may be presented verbally or in writing and may include...treatment, care, lost personal items...The assigned Department Head/Designee investigates the concern and takes action to correct the issue within 48 hours. 72 hours if on a Friday evening or Saturday...Grievances must be completed with appropriate actions as well, within 5 days from submission." .	F 244	the Resident Council meeting were addressed. The reports will continue on an ongoing basis. Date corrective action completed. All parts of this plan will be completed by 2-28-16	
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248		2/28/16

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F 248	Continued From page 14 This REQUIREMENT is not met as evidenced by: . Based on record review the facility failed to provide an activity program designed to meet the wishes of the residents who attended the Resident Council meetings. (based on the 3-4 documented number of residents who attended the meetings). Findings: Review of the Resident Council meeting minutes for 2015 revealed "Suggestions for any special activities?" The following were documented suggestions made by residents: Knitting; Yarn work; Embroidery; Skin sewing; Wood working crafts; More rides (vehicle); Going outside more; Fiddle dancing; Playing cards; Chinese checkers; Going to the VFW to play bingo; More shopping; Bible study; and More native dancing in the gathering room. Review of the Activity Calendar, dated January 2016, revealed no knitting, yarn work, embroidery, skin sewing, wood working crafts, fiddle dancing, Chinese checkers, bingo at the VFW, and native dancing were on the activity calendar. 9 out of the 14 resident suggestions for special activities was not on the calendar. There was no documented reason in the Resident Council meeting minutes as to why these	F 248	F248 Activities to meet interests/needs of each resident Corrective action for identified residents. No specific residents were identified Identify residents who also may be affected and corrective action for them. The facility held a resident council meeting and reviewed the listed unaddressed concerns indentified in this statement to see if follow up could be completed. Residents were asked specifically for suggestions for activities. The Activity Coordinator will include these suggestions if possible and will report to the residents at the next regular scheduled meeting why some of the suggested activities could not be included. Alternative activities will be suggested to the group based on activities that could not be included. System changes to prevent practice from reoccurring. The facility Administrator and Activity Coordinator reviewed and revised the Activity policy. The facility Administrator arranged for additional education for the Activity Coordinator based on F248 interpretive guidelines. New activity assessments will be completed by the Activity Coordinator for all residents. The results of the new activity assessments will be reviewed by the Activity Department Consultant. This	

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F 248	Continued From page 15 requested activities were not going to be resident activities. Review of the policy "LTC [Long Term Care] Activity Calendar", dated 10/1/13, revealed "The Activity Coordinator will ensure that calendars are designed with input from the residents." .	F 248	consultant will meet the qualifications for Activity Coordinator as described in F249. The activity programming will be changed to include as many new activities as possible. The Activity Coordinator will be responsible to make sure the assessments are completed, reviewed by the consultant and results used on subsequent activity calendars. The Activity Department Consultant will provide monthly education to the Activity Coordinator with the goal of increasing the variety of activity choices available. The revision of the Resident Council policy will ensure suggested activities made during resident council meetings are included in the activity programming when possible. Quality assurance program that will monitor to prevent reoccurring. The Activity Coordinator/designee will interview 5 residents per month to see if they are satisfied with the variety of activities offered. The results of the monthly audits will be report to the QAPI committee on a monthly basis. The audits and reports will continue for 3 months and then as directed by the QAPI committee. The Resident Council report given to the QAPI on a monthly basis as part of the F244 plan of correction will include suggested activities. The Resident Council report will continue on an ongoing basis. Date corrective action completed.	

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F 248	Continued From page 16	F 248	All parts of this plan will be completed by 2-28-16	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: . Based on record review and interview, the facility failed to develop and revise comprehensive care plans that addressed specific needs and instructions for 4 residents (#s 2, 3, 4 and 8) out of 7 sampled residents whose care plans were reviewed. Specifically, the care plans were not care planned in the following areas: 1) dehydration - fluid maintenance; 2) pressure	F 279	F279 Develop comprehensive care plans Corrective action for identified residents. Resident #2 care plan was updated to include the potential for dehydration, fluid maintenance, pressure ulcers and psychotropic drug use. Resident #4 care plan was updated to include dehydration-fluid maintenance. The Director of Nursing completed the update	2/28/16

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F 279	Continued From page 17 ulcers; 3) psychotropic drug use; and 4) activities. Without appropriate care plan interventions and coordination, residents were at risk for not receiving the necessary and/or appropriate care and services to ensure optimal outcomes. Findings: Resident #2 Record review from 1/12-14/16 revealed Resident #2 had diagnoses that included dementia, hypertension, behaviors and chronic kidney disease. Review of the most recent MDS (Minimum Data Set) assessment, an annual assessment dated 12/1/15, revealed the Resident was triggered on the care area assessment (CAA) for dehydration - fluid maintenance, pressure ulcers and psychotropic drug use. The CAA also was checked by the facility for requiring care planning. Review of the most recent comprehensive care plan last updated 12/14/15 revealed, no care plan for dehydration - fluid maintenance; pressure ulcers; or psychotropic drug use. During an interview on 1/13/16 at 2:25 pm, the Director of Nursing (DON) confirmed there was no care planning done for these triggered areas and there was no documentation as to the reasons why they were not care planned. Resident #3 Record review from 1/11-14/16 revealed Resident #3 had diagnoses that included anxiety, agitation,	F 279	for resident #2 and # 4. Resident #3 care plan was updated to include activities. Resident #8 care plan was updated to include activities. The Activity Coordinator completed the update for resident #3 and #8 Identify residents who also may be affected and corrective action for them. All care plans were reviewed by the Director of Nursing/designee. Care Plans were updated as needed. Staff were informed of any changes via Care Tracker and the RAVEN IPOC system System changes to prevent practice from reoccurring. The MDS RN Coordinator and Director of Nursing have been educated on the need to have care plans that are brief yet address medical problems. Education included the requirement to include the CAA from the MDS when developing care plans. The most recent CAA will be printed and available for review by all Licensed Nurses. The Director of Nursing/designee will be responsible to review the RAVEN IPOC care plan for each resident on a monthly basis and compare the content with the most recent CAA. Any missing problems will be corrected immediately. Licensed Nursing staff were educated on the need to update care plans when resident conditions change and on how the CAA needs to be incorporated into the resident care plan. The education included written testing.	

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F 279	Continued From page 18 and dementia. Review of the most recent significant change MDS assessment dated 4/3/15, revealed Resident #3 triggered for a CAA related to activities. Review of Resident #3's care plan, last updated 12/20/15 revealed no care plan for activities. During an interview on 1/13/15 at 9:35 am the DON confirmed Resident #3 did not have a care plan for activities and should have had one in place. Resident #4 Record review from 1/12-14/16 revealed Resident #4 had diagnoses that included late effects of cerebral vascular accident (stroke) and diabetes. Review of the most recent annual MDS assessment, dated 8/28/15, revealed the Resident was triggered on the CAA for dehydration - fluid maintenance. The trigger also was checked by the facility for requiring a care plan. Review of the most recent comprehensive care plan, dated 11/5/15, revealed no care plan for dehydration - fluid maintenance. During an interview on 1/13/16 at 2:25 pm, the DON confirmed there was no care plan for dehydration - fluid maintenance as triggered on the CAA and there was no documentation as to the reason why it was not care planned.	F 279	Quality assurance program that will monitor to prevent reoccurring. The Director of Nursing/designee will complete an audit of 6 care plans per month (1/3 of the residents). The audit will include reviewing the current medical needs of the resident and comparing them to the care plan and most recent CAA. Any problems will be corrected immediately. A report of this audit will be submitted to the QAPI Committee on a monthly basis. The reports will continue for 6 months and then as directed by the QAPI Committee. Date corrective action completed. All parts of this plan will be completed by 2-28-16	

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F 279	Continued From page 19 Record review on 1/14/16 at 2:00 pm of the facility's policy & procedure, "LTC Fluid Enhancement" with the effective date of 10/1/13, revealed, "When a resident has been assessed that additional fluids are appropriate, the care plan will be developed to include a FEP [fluid enhancement program]." Record review of the facility's policy and procedure for "LTC [Long Term Care] MDS-Quarterly Assessment-Care Plan Review", with an effective date of 10/1/13, revealed "Revisions in the care plan will be completed to identify the resident's current needs." Resident #8 Record review on 11/14/16 revealed Resident #8 was admitted to the facility on 11/2/15. Further review revealed the Resident had diagnoses that included adult failure to thrive and dementia. Review of the most recent MDS assessment, an admission assessment dated 11/6/15, revealed the Resident was interviewed for activity preferences. During an interview on 1/12/16 at 3:25 pm the Administrator stated activity assessments are done on the MDS. Review of the Resident's care plan on 1/14/16 revealed activities was not part of the plan of care. Record review of the facility's policy and procedure for LTC Activity Assessment & Care Plan, with an effective date of 10/1/13, revealed "The Activity Coordinator will assess each	F 279		

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F 279	Continued From page 20 resident within 14 days of admission...The Activity Coordinator will participate in Care Plans for the resident, these care plans will be held: 72 hours of admission, 30 days of admission, 90 days from admission, Quarterly, Annually and with any changes." .	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: . Based on record review, interview and document review the facility failed to ensure a qualified staff member was feeding 1 resident (#10) out of 15 residents in accordance with the care plan. This failed practice placed the resident at risk of improper feeding techniques and complications related to feeding. Findings: Record review from 1/11-14/16 revealed Resident #10 had a diagnosis of CVA (cardiovascular accident - sudden death of brain cells due to the lack of oxygen when blood flow to the brain is impaired by blockage or rupture of an artery to the brain). Review of the Residents care plan, last updated 10/16/15, revealed "alteration in nutrition" with the interventions listed as having a pureed, nectar thick diet; assist with feeding by using a spoon;	F 282	F282 Services by qualified persons/per care plan Corrective action for identified residents. Resident #10 was assessed and no complications from improper feeding was noted. The Activity Coordinator will not help resident #10 or any other resident to eat. Identify residents who also may be affected and corrective action for them. All staff that help resident to eat are qualified to perform eating assistance. This will protect all other residents. System changes to prevent practice from reoccurring. The Activity Coordinator will not be allowed to help resident to eat until she has a current Certified Nursing Assistant	2/28/16

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F 282	Continued From page 21 ensure the Resident swallowed all food; and ensure mouth is clear after feeding. Observations from 1/11-12/16 revealed the Activities Coordinator feeding Resident #10 a pureed diet with nectar thick liquids. During an interview on 1/13/16 at 12:59 pm the Administrator stated the Activities Coordinator was not currently a certified nursing assistant. During an interview on 1/13/16 at 1:45 pm the Registered Dietician (RD) stated only a certified nursing assistant or Licensed Nurse could feed Resident #10. In addition, the RD confirmed the Resident was on a pureed food diet with nectar thick liquids. Review of the Activities Coordinator's job description, dated 2/11/14, revealed no job duties that included feeding residents. .	F 282	certificate. She completed the CNA class in December 2015 and should have the certificate within 90 days. Once she has the certificate her job description will be updated to include helping residents to eat. All facility staff have been educated on the requirement to be certified or licensed in order to help residents to eat. Education included written testing. Quality assurance program that will monitor to prevent reoccurring. The Administrator/designee will complete an audit of 5 facility randomly selected staff one time per month to see if they can correctly describe who can help residents to eat. The Administrator/designee will submit a report based on this audit to the QAPI committee once per month. Audits and reports will continue for 3 months and then as directed by the QAPI committee. Date corrective action completed. All parts of this plan will be completed by 2-28-16	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: .	F 332	F332 Free of medication error rates of	2/28/16

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F 332	Continued From page 22 Based on record review, observation, and interview the facility failed to ensure 1 resident (#2), out of 6 residents observed during medication administration, received medications per physician's orders and manufacturer's recommendations. Specifically, the facility failed to 1)follow the physician's order for rinsing the mouth after administering an inhaled medication and 2) failed to administer inhaled medication per manufacturer's recommendation. These failed practices placed the facility's medication error rate above 5% and placed the resident at risk for not receiving a therapeutic dose and increased the risk for adverse side effects from the medications. Findings: Record review from 1/12-13/16 revealed Resident #2 had a diagnosis of congestive obstructive pulmonary disease (COPD, a chronic lung disorders that results in blocked air flow in the lungs). Review of the Medication Administration Record (MAR) revealed the Resident's medication regime included: Dulcera - "formoterol-mometasone (Dulcera 100 mcg-2 puff(s), Inhalation, form: Aerosol, BID [2 times a day]...wash mouth out after use". Spiriva - "tiotropium [an inhaled medication that relaxes the airways] 18 mcg , = 1 inh, Inhalation, form: Powder-Inh, Daily..." Observation during a medication administration pass on 1/12/16 at 8:15 am revealed, LN #3 administered the ordered inhalation therapy to Resident #2. First, LN #3 administered 1 puff of Dulcera and after waiting 2 seconds,	F 332	5% or more Corrective action for identified residents. Resident #2 was assessed for any adverse affects from the inhalation medication being administrated incorrectly. Results were documented in the medical record. Identify residents who also may be affected and corrective action for them. By making the system changes all resident will be protected. System changes to prevent practice from reoccurring. The Director of Nursing reviewed and revised the Medication Administrator policy. This policy includes resources licensed nurses can access via computer to help them understand appropriate inhaler medication. The policy includes using proper hand hygiene during medication administration. All licensed Nursing staff were educated on the new policy. Education included observation of medication pass by another licensed nurse. A written test was also included as part of the education. Licensed nursing staff were required to achieve a 100% on both the observation and written test. The Director of Nursing was responsible to ensure education, observations and testing were completed. Quality assurance program that will monitor to prevent reoccurring. The Director of Nursing/designee will observe 3 licensed nurses pass medication each month. The Chief Nurse	

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F 332	Continued From page 23 administered a second puff of Dulcera. Then, 2 seconds later, LN #3 administered 1 inhalation of Spiriva using the "HandiHaler" device (a medication device used for inhaling medication). The nurse did not offer Resident #2 the opportunity to rinse his/her mouth with water as instructed on the MAR. During an interview on 1/12/16 at 8:20 am, LN #3 stated, "[the Resident] should have rinsed. I should have offered water after the inhaler." During an interview on 1/12/16 at 1:45 pm, the Pharmacist stated 2 seconds is not long enough between inhalations of Dulcera. The Pharmacist further stated, "There should be at least 5 seconds between the inhalations in order to get the medication into the lungs." Review of the manufacturer's package insert, dated 2010, for "DULCERA", provided by the Pharmacist on 1/13/16 at 10:00 am, revealed the following inhalation instructions, "When you have finished breathing in, hold your breath as long as you comfortably can, up to 10 seconds..." Review of the manufacturer's package insert, revised April 2014, for "Spiriva HandiHaler", provided by the Pharmacist on 1/13/16 at 10:00 am, revealed "Remember: To get your full daily dose, you must again, breath out completely and for a second time, breath in...from the same SPIRIVA capsule." During a subsequent interview on 1/13/16 at 10:05 am, after reviewing the manufacturer's package insert for Spiriva, the Pharmacist confirmed Spiriva should be inhaled 2 times to get the full dose.	F 332	Executive/designee will use the same audit tool used by state surveyors to determine compliance with F332. Licensed nurses who don□t achieve a passing score will be re-educated by the Director of Nursing. The Director of Nursing will report the results of the observations to the QAPI committee on a monthly basis for 6 months. After 6 months the QAPI committee will determine the frequency of additional medication audits. Date corrective action completed. All parts of this plan will be completed by 2-28-16	

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F 332	Continued From page 24 Review on 1/14/16 at 4:00 pm of the facility's policy and procedure for Medication Administration dated 10/1/13 revealed, "Medications will be prepared and administered in accordance with: A. Physician's orders; B. Manufacturer's specifications regarding the preparation and administration..." .	F 332		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356		2/28/16

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F 356	Continued From page 25 The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: . Based on observation, interview and record review, the facility failed to ensure: 1) the daily nurse staffing and resident census information was posted; and 2) the facility maintained 18 months worth of the posted daily nurse staffing data. Failure to post and to keep 18 months of the nurse staffing and resident census information denied residents, family, and other visitors the right to know the numbers of licensed and unlicensed staff available who were responsible for resident care and the number of residents in their care for a census of 15 residents. Findings: Nursing Staffing/Resident Census Postings: Observation during the initial tour on 1/11/16 at 8:55 am revealed a plastic wall hanging holder on the wall between the 200 and 300 wings of the facility, with "Daily Staffing Report" forms that were blank. No information related to the daily nurse staffing and resident census information was posted. During an interview on 1/11/16 at 9:00 am, the Administrative Assistant (AA) stated, Licensed Nurse (LN) #3 was responsible for completing and posting the daily information. During an interview on 1/11/16 at 9:15 am LN #3	F 356	F356 Posted nursing staffing Corrective action for identified residents. No specific residents were identified Identify residents who also may be affected and corrective action for them. By making the system changes all resident will be protected. System changes to prevent practice from reoccurring. The facility Administrator and Director of Nursing reviewed and revised the Nurse Staff Posting policy. All licensed Nurses and the Administrative Assistant were educated on the new policy. Quality assurance program that will monitor to prevent reoccurring. Each work day, the Administrative Assistant will collect the previous day(s) Nurse Staff Level form. The Administrative Assistant will be responsible to archive the form for 18 months. Any time the Administrative Assistant discovers that the form was not completed or it is missing an e-mail will be sent to the Director of Nursing and the facility Administrator. The Director of Nursing will be responsible to follow up with the licensed Nursing staff.	

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F 356	Continued From page 26 stated s/he had been on leave for 6 months and just returned 1 week ago. LN #3 further stated s/he was unaware it was her/his responsibility to complete the daily nurse staffing/resident census information until today. During an interview on 1/12/16 at 8:35 am, the Director of Nursing (DON) confirmed the facility had not posted the nursing staffing/resident census report sheet and said "they were not there yesterday." During an interview on 1/12/16 at 8:45 am, the AA stated the information was not posted from 1/7-11/16. The AA further said, "I pick them up on Monday and they [the forms in the plastic wall holder]was empty." Retention of 18 months of Posted Daily Nurse Staffing Data: Record review on 1/12/16 revealed the facility was not able to provide 18 months of nurse staffing/resident census information. The facility was able to provide documentation of the posted nurse staffing data for 11/20-27/14, and for the calendar year of 2015 with various missing days. During an interview with the Administrator on 1/12/16 at 7:15 am, the Administrator stated the procedure was for the AA to pick up and keep the nursing staffing/resident census sheets. During an interview on 1/12/16 at 8:45 am, the AA confirmed the facility was missing 6 months of the posted nurse/staffing information. .	F 356	The Director of Nursing/designee will prepare a report each month for the QAPI committee the report will list any days the Nurse Staffing Report was not posted and the name of the staff who failed to post the report. The QAPI committee will review this report and direct any follow up. The reports to the QAPI will continue for 6 months. Date corrective action completed. All parts of this plan will be completed by 2-28-16	

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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 This REQUIREMENT is not met as evidenced by: . Based on observation, interview and record review the facility failed to ensure: 1) temperature monitoring of the food refrigerators; 2) monitoring food temperature prior to serving; 3) daily cleaning of kitchen appliances; and 4) hair nets are worn during food preparation. These failed practices created a potential for food contamination and increased the risk for food-borne illnesses. Findings: No Thermometer in the 200 Unit Refrigerator: Random observations from 1/11-12/16 revealed there was no thermometer in the 200 unit refrigerator. During an interview on 1/11/16 at 10:10 am, the Dietary Manager (DM) confirmed there was no thermometer in the 200 unit refrigerator. Record review from 1/11-14/16 of refrigerator and freezer temperature monitoring logs from the 200 and 300 units, revealed no monitoring documentation.	F 371	F371 Food procure, store/prepare/serve-sanitary manner Corrective action for identified residents. No specific residents were identified Identify residents who also may be affected and corrective action for them. By making the system changes all resident will be protected. System changes to prevent practice from reoccurring. The Executive Chef reviewed and revised the education provided to all Dietary staff. The revised education was reviewed and approved by the consulting Dietitian. All Dietary staff were educated. The education focused on the need to monitor food refrigerator and freezer temperatures, maintain proper food temperature logs, completing daily cleaning checklists and using hairnets while preparing food. Dietary staff will be required to complete and sign a daily	2/28/16

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F 371	Continued From page 28 Observations on 1/14/16 at 2:00 pm revealed refrigerator and freezer temperature's in the 200 and 300 unit kitchens were not being monitored and logs not maintained. Main Kitchen An observation of the main kitchen on 1/14/16 at 1:30 pm revealed temperature logs on the freezer and the 2 refrigerators. Review of the temperature logs revealed no temperature had been recorded from 1/12-14/16. During an interview on 1/14/16 the Administrator confirmed the temperature of the freezer and the refrigerators in the main kitchen had not been recorded from 1/12-14/16. Food Temperature: Observation on 1/11/16 at 9:45 am, in the main kitchen, revealed cream of wheat and scrambled eggs were served for breakfast. Review of the food temperature log revealed only the scrambled eggs had been tested for temperature. During an interview with DM who was in the kitchen at the time of observation confirmed the temperature for cream of wheat had not been documented. Dirty Kitchen Appliances: Observation on 1/11/16 at 9:40 am in the main kitchen revealed, the Tea/Coffee Bunn was dirty with multiple dried spills on the top and sides of	F 371	cleaning list. The list will be turned into the Executive Chef. Education included return demonstration on thermometer reading, thermometer calibration, and written testing on cleaning checklists. The Executive Chef was responsible to ensure all education for dietary staff was completed. Nursing was educated on the need to wear hair nets while preparing food in the native kitchens. They may serve trays without using a hair nets. The director of Nursing is responsible to ensure all Nursing Staff know to use hair nets while preparing food. Quality assurance program that will monitor to prevent reoccurring. Each work day the Executive Chef will check to ensure food temperature logs and refrigerator and freezer temperatures are up to date. The Executive Chef will ensure all cleaning check list were turned in and the work completed satisfactorily. The Executive Chef will be responsible for any follow up. Each month the Consultant Dietitian will complete a sanitation audit of the kitchen. The Executive Chef will be responsible for any follow up from the audit. The Executive Chef will also report to the QAPI on a monthly basis the results of the Consultant Dietitian sanitation audit, results of refrigerator and freezer temperature log review and the results of the food temperature log review. These reviews and audits will continue on an	

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F 371	Continued From page 29 the appliance. During an interview with DM who was in the kitchen at the time of observation confirmed, "Tea Bunn is dirty." He added that they get cleaned once weekly usually on Wednesdays. Hair Net - 200 Unit Resident Kitchen: Observation on 1/12/16 at 7:25 pm revealed Certified Nursing Assistant (CNA) #4 preparing a peanut butter and jelly sandwich in the Resident kitchen on the 200 unit and was not wearing a hair net. During an interview on 1/12/16 at 7:40 pm, CNA #4 stated there were no hair nets available in the kitchen. During an interview on 1/14/16 at 10:45 am, the Director of Nursing (DON) stated she was unaware that staff needed to wear a hair net while preparing food in the Resident kitchen. .	F 371	ongoing basis. The Administrator/designee will complete an audit of 5 randomly selected facility staff members, one time per month to see if they can correctly identify when to wear hair nets. The Administrator/designee will submit a report based on this audit to the QAPI committee once per month. Audits and reports will continue for 3 months and then as directed by the QAPI committee. Date corrective action completed. All parts of this plan will be completed by 2-28-16	
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. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 431		2/28/16

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F 431	Continued From page 30 appropriate accessory and cautionary instructions, and the expiration date when applicable. 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. 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. This REQUIREMENT is not met as evidenced by: . Based on observation, interview and record review, the facility failed to ensure vaccines kept in the medication room refrigerator were monitored per Centers for Disease Control and State of Alaska Immunization guidelines. Specifically, the facility failed to have a system in place for recording 24 hour temperatures of the refrigerator that stored vaccines. This failed practice had the potential to affect all residents (census of 15) who required vaccines. Findings: Observation on 1/12/16 at 8:05 pm of the medication refrigerator on the 300 wing, revealed the following vaccines in the refrigerator:	F 431	F431 Corrective action for identified residents. No specific residents were identified Identify residents who also may be affected and corrective action for them. The vaccines were returned to the Immunization Department. By changing the system all residents will be protected System changes to prevent practice from reoccurring. After reviewing the medication refrigerator operating manual the Director of Nursing was able to determine that the refrigerator	

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F 431	Continued From page 31 Pneumococcal 13 (PCV13) - 10 single dose vials; Pneumococcal 23 (PPSV23) - 4 single dose vials; and Tetanus, diphtheria, pertussis (Tdap) - 5 single dose vials. During an interview on 1/13/16 at 10:30 am, the Vaccine Distribution Technician stated s/he did not have any responsibility for vaccines once they brought them over from the hospital to the long term care (LTC). During an interview on 1/13/16 at 11:00 am, the Administrator stated he was unaware that vaccines were stored in the refrigerator. During an interview on 1/13/16 at 4:05 pm, the Vaccine Distribution Technician stated the facility did not have a process for 24 hour monitoring of the vaccine refrigerator temperatures. During an interview on 1/14/16 at 4:40 pm, the Administrator confirmed, there was not a process in place that monitored the temperatures of the vaccine refrigerator for 24 hours. The Centers for Disease Control and Prevention "Vaccine Storage and Handling Toolkit" 2014, obtained at http://www.ded.gov.vaccines website, revealed, "CDC recommends use of a continuous monitoring device/digital data logger to record and store temperature information at frequent programmable intervals for 24-hour temperature monitoring." The State of Alaska Immunization "Alaska Vaccine Distribution Handbook" revised January	F 431	temperatures are monitored constantly. An alarm would sound if the refrigerator temperature ever exceeded or fell below the set temperature. The Director of Nursing developed a policy and education plan for all Licensed Nurses. All licensed Nurses were educated on the refrigerator temperature monitoring policy. Education included return demonstration on addressing any alarms. Education included written testing. Quality assurance program that will monitor to prevent reoccurring. The medication refrigerator temperature log will be reviewed by the Director of Nursing each month. Any problems noted will be followed up. A report of the review will be given to the QAPI committee each month for 3 months and then as directed by the QAPI committee. Date corrective action completed. All parts of this plan will be completed by 2-28-16	

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F 431	Continued From page 32 2015, obtained at http://dhss.alaska.gov website, revealed, "Temperatures in all vaccine storage units must be monitored...Temperature monitoring devices must be placed in each vaccine storage unit...Improper placement of the monitor may result in vaccine wastage. All other vaccine refrigerators/freezers (temporary or day use storage units) must be monitored by using a calibrated temperature monitoring device supplied by your facility." The facility did not provide the refrigerator temperature/alarm settings or the vaccine refrigerator manufacturer's information as requested prior to exit. Additionally, the facility did not provide the policy and procedures for vaccine storage as requested prior to exit. .	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 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441		2/28/16

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F 441	Continued From page 33 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: . Based on record review, observation and interview, the facility failed to:1) ensure good hand hygiene practices for one resident (#5) out of 4 observed; 2) ensure surveillance of staff and personnel processing laundry in a manner to prevent cross contamination; 3) ensure staff use good aseptic technique during medication handling/pass; and 4) have a formal infection control program. These failed practices increased the risk for the development and transmission of disease and infection in a vulnerable population. Findings: Hand Hygiene: Record review on 1/11-14/16 revealed Resident	F 441	F441 Infection control, prevent spread, linens Corrective action for identified residents. Resident #5 was assessed and no adverse effects were found from not providing hand hygiene. Results of the assessment were placed in the medical chart. Identify residents who also may be affected and corrective action for them. By changing the system all residents will be protected System changes to prevent practice from reoccurring. The Director of Nursing developed a	

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F 441	Continued From page 34 #5 was admitted to the facility with diagnoses that included blindness and stroke. The Resident's care plan stated the Resident's mobility was to scoot around the floor and to feel for objects. Observation during the initial tour on 1/11/16 from 8:30 am - 9:30 am revealed dirty carpet on both the 200 and 300 units of the facility. During an observation on 1/11/16 at 11:45 am revealed Resident #5 scooting around the floor on her/his bottom, with both hands on the dirty carpet in the TV area. Observation on 1/11/16 at 12:00 pm revealed Resident # 5 was assisted to the wheelchair by Certified Nursing Assistant (CNA) #2 from the floor and transported to the dining table to have noon meal. Continuous observation until 12:55 pm revealed hand hygiene was not provided to the Resident prior to serving the food, even though the Resident's hands had been on the dirty carpet. Observation on 1/12/16 at 7:10 pm revealed Resident #5 sitting on the dirty carpeted floor scooting around on her/his bottom with both hands. The Resident was assisted to the wheelchair by CNA #4 and transported to the dining table for an evening snack. Continuous observation until 7:35 pm revealed hand hygiene was not provided to the Resident prior to the snack. Observation on 1/13/16 during lunch at 12:15 pm, revealed Resident #5 was scratching an area above the left buttock under her/his clothing while dining. Licensed Nurse (LN) #4, who was assisting the Resident with dining at this time, did	F 441	policy on providing hand hygiene to residents. All nursing staff were educated on the policy. Education included written testing. The facility Administrator reviewed and revised the soiled linen handling policy. Sorting bins were purchased to keep soiled linen off the floor while being sorted. All Environmental Service staff were educated on the policy. Education included return demonstration and written testing. The Director of Nursing reviewed and revised the policy on Nursing Staff handling of soiled linen. All nursing staff were educated on the policy. Education included written testing. The revised medication administration policy and training for F332 addresses hand hygiene. The facility Administrator will be responsible to ensure the facility is included in the corporate wide Infection Control Risk Assessment. Copies of the current corporate wide plan was used to develop an education for all facility staff. Education included posters and signs posted throughout the facility. The Director of Nursing was provided education on infection control. The education was provided by the Chief Nurse Executive and included written testing. The Director of Nursing will be responsible to ensure that monthly infection control audits are completed.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKON KUSKOKWIM ELDER'S HOME	1100 CHIEF EDDIE HOFFMAN HWY, PO BOX 528 BETHEL, AK 99559

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F 441	Continued From page 35 not offer hand hygiene to the Resident. During this observation the Resident was seen holding bowl and spoon during the meal feeding his/her self with intermittent assistance by staff. Review on 1/20/16 of CDC's article "Handwashing: Clean Hands Saves Life", last reviewed 9/4/15, retrieved at http://www.cdc.gov/handwashing/when-how-hand washing.htmlm revealed person should wash hands before eating. Review of the facilities policy index revealed no policies for resident hand hygiene practice before dining. Laundry: Observation on 1/11/16 at 9:19 am of the 200 unit washer room revealed multiple piles of laundry on the floor. During an interview on 1/11/16 at 9:19 am Environmental Services (ES) Staff #1 stated soiled linen is brought into the washer room and separated on the floor. Observation on 1/12/16 at 8:55 am revealed LN #2 carried soiled resident clothing from a Resident #3's room through corridor. The LN placed the clothing in an open soiled laundry cart located outside the unit's laundry room without wearing personal/staff clothing protection. During an interview on 1/12/16 at 7:05 pm CNA #1 stated when providing peri-care to a resident the soiled brief would be placed in the garbage can and the clothing removed would be placed on top of the garbage can. The CNA continued to	F 441	Any concerns noted in the audits will be corrected. Quality assurance program that will monitor to prevent reoccurring. On a monthly basis, the Director of Nursing will report to the QAPI committee the results of the monthly infection control audit. The reports will be given on an ongoing basis One time per quarter the Chief Nurse Executive, facility Administrator, Director of Nursing, Pharmacy Consultant, Dietitian, Executive Chef, Activity Coordinator, Social Worker and Activity Coordinator will meet and review the current corporate wide infection control plan and review any recommendations made by the corporate Infection Control committee. Minutes of this meeting will be available for all staff to review. Date corrective action completed. All parts of this plan will be completed by 2-28-16	

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F 441	Continued From page 36 state when cares are completed, he/she would carry the soiled clothing through the corridor to the soiled laundry containers located in the hallway of the unit without personal protective equipment (PPE). Observation on 1/13/16 at 10:32 am, ES Staff #1 transported an uncovered clean laundry cart to the folding room. During an interview on 1/13/16 at 10:32 am revealed ES Staff #1 stated he/she separated soiled laundry on the floor of the washer room and that staff place soiled laundry in the dirty laundry containers without bagging them first. In addition, stated staff only wore gloves and no clothing protection when handling soiled linen. Laundry Bin: Random observation from 1/11-14/16 revealed two soiled laundry containers with lids affixed in the upright position on both 200 and 300 unit. In addition, a large mobile blue laundry cart labeled "dirty" was uncovered with obviously soiled resident clothing exposed on both 200 and 300 unit. Observation during the initial tour on 1/11/16 from 8:30 am - 9:30 am revealed 2 upright linen containers in the back hallway of each unit, with the lids open. Written on the inside of the lids in large print, visible when the lids were open, were the words "Dirty Linen" Random observations revealed one large blue open bin without covers on each unit. Further observation on 1/11/16 at 12:39 pm of the 300 wing revealed, loose dirty linen was placed in	F 441		

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F 441	Continued From page 37 one of the upright bins; the lid was opened. Observation of the large blue bin revealed both loose linen and linen wrapped in plastic bags were in the bin. Observation on 1/12/16 at 7:18 am of the 300 wing, revealed unwrapped linen in both upright bins with the lids open and loose dirty linen overflowing in the large blue bin. During an interview on 1/14/ 16 at 7:25 am the Administrator was asked for a policy on the handling and storage of dirty linens. No policy was provided by the time of exit. Medication Handling/Pass: Observation during a medication pass on 1/12/16 at 8:10 am revealed LN #3 removed a medication capsule from a blister pack (Spiriva) and placed the capsule in her bare hand. The LN then used her bare fingers to pick up the capsule and place it in a "HandiHaler device" (a medication device used for inhaling medication). Further observation revealed LN #3 then took the medication to Resident #2's room and administered the medication. During an observation on 1/13/16 at 8:30 am LN #1 opened a bottle of miralax by taking an ungloved hand and breaking the metallic-colored seal with index finger. The LN then ran an ungloved finger around in the inside rim of the bottle to remove remnants of the seal. Infection Control Program: During an interview on 1/14/16 at 10:17 am the Director of Nursing (DON) was asked who the	F 441		

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F 441	Continued From page 38 Infection Preventionist for the facility was. The DON said she was responsible for infection control since August 2015. The committee consisted of the Administrator, Kitchen Manager, Activities Coordinator, MDS (Minimum Data Set) Nurse, and the Social Worker, when the facility had one on staff, and the Medical Director attended the meetings sometimes on Wednesdays, as her schedule allowed. During an interview on 1/13/16 at 9:20 am, the Pharmacist stated s/he had never attended an Infection Control meeting at the long-term care facility. However, the Pharmacist stated s/he did receive a copy of the meeting minutes up until January of 2015. During the interview the DON revealed 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 since 2013. This was confirmed by the Administrator. In addition, when asked for the infection control committee minutes she stated the facility did not have any minutes and stated there was no formal infection control program. .	F 441		
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.	F 518		2/28/16

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F 518	Continued From page 39 This REQUIREMENT is not met as evidenced by: . Based on personnel file review and interview the facility failed to ensure 7 out of 9 staff personnel files reviewed contained fire emergency training. This failed practice placed all residents at risk for delayed evacuation and response from staff due to potential lack of fire emergency training. Findings: During an interview on 1/13/16 Human Resources (HR) Staff #1 stated fire and life safety training would be under section 3 of each staff's personnel file. Review of the personnel files on 1/13/16 revealed no recent fire emergency training for Certified Nursing Assistant (CNA) #s 1, 3, 4, 5 and 6. Additional review revealed no recent fire emergency training for Licensed Nurse #3 or Cook #3. Review of training documents provided by the Director of Nursing on 1/14/16 did not contain any recent fire emergency training for CNA #s 1, 3, 4, 5 and 6. Additional review revealed no recent fire emergency training for Licensed Nurse #3 or Cook #3. .	F 518	F518 Train all staff emergency procedures/drills Corrective action for identified residents. No specific residents were identified. This Deficiency was related to staff having records of emergency procedure training on file in their personal records maintained by Human Resources. Identify residents who also may be affected and corrective action for them. All facility staff personal files were reviewed by Human Resource staff and any missing record of emergency procedure training were identified. The facility Administrator was responsible to ensure the staff missing any education received the education. System changes to prevent practice from reoccurring. Human Resource staff will be responsible to implement a system to ensure all Long Term Care Staff have records of current emergency procedure training in their personal records. The emergency procedure training is completed at the time of hire and again every October. Anyone hired before August is required to complete emergency procedure training. The training is traced via a computer program named Health Stream. Human Resource staff will ensure someone in Human Resources has the training and access to the Health Stream system so	

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F 518	Continued From page 40	F 518	records for the training can be provided as required. Quality assurance program that will monitor to prevent reoccurring. Human Resource staff will complete an audit no later than 30 days after date of hire on all Long Term Care employees. This audit will include ensuring facility staff have completed emergency procedure training as part of the new hire orientation. The Human Resource staff will also monitor and report the completion of the annual employee orientation for all Long Term Care employees. The results of the monitoring of this training will be reported to the facility Administrator and a report will be submitted to the monthly QAPI committee. The Human Resource audits on emergency procedure training will continue on an ongoing basis. Date corrective action completed. All parts of this plan will be completed by 2-28-16	