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

PRINTED: 10/06/2011
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535024 | A. BUILDING _____ B. WING _____ | 09/22/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| POPLAR LIVING CENTER | 4305 S POPLAR CASPER, WY 82601 |

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| F 000 | INITIAL COMMENTS<br><br>The following common abbreviations are used throughout this document:<br>RN: registered nurse<br>CNA: certified nursing assistant<br>DON: director of nursing<br>MDS: Minimum Data Set<br>LPN: licensed practical nurse<br><br>Less commonly used abbreviations will be annotated in each deficiency where used. | F 000 | Preparation and/or execution of this plan of correction does not constitute 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.<br><br>This plan of correction is the facility's allegation of compliance. | |
| F 244 SS=E | 483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on review of resident council meeting minutes, and resident and staff interview, the facility failed to respond to the resident council related to 1 of 1 unresolved group grievances. The findings were:<br><br>Review of the resident council meeting minutes for June and July 2011 showed a concern regarding missing clothing. Review of the August 2011 minutes revealed missing clothing was not noted as a concern; however, there was nothing to show the issue was resolved. Confidential interviews with sixteen residents on 9/20/11 revealed that missing clothing remained an issue | F 244 | F244<br><br>It is the practice of the facility to ensure that when a resident or family group exists, the facility will 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.<br><br>**Corrective Action**<br>The resident council concern regarding missing clothing items was reviewed with regards to the actions taken and plan at the next resident council meeting.<br><br>**Identification of Others**<br>An audit of the resident council minutes for the last three months will be conducted for unresolved concerns. Any identified unresolved concerns will be documented on a concern form for resolution by the IDT.<br><br>**Systemic Changes**<br>The Activities Director or designee will continue to review previous identified concerns and resolution with the resident council on a monthly basis. Any noted concerns will be documented on the Resident Council Concern Form and will be assigned to the appropriate department manager for prompt follow-up. | 11/04/2011 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dennis Toyano | TITLE: Administrator | (X6) DATE: 10/15/11

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 those 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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Wyoming Department of Health

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: TQF311 Facility ID: WY0029 If continuation sheet Page 1 of 18

Plan of Correction was accepted with corrections per conversation with the Administrator Dennis Toyano 10/26/11 at 3pm Kathryn Kelly Health Surveyor

OCT 15 2011

Office of Healthcare Licensing and Surveys

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| F 244 | Continued From page 1<br>and the facility had failed to follow-up with the group in regard to the status of their concerns. During an interview with the administrator in training on 9/20/11 at 2:15 PM, she verified the group had not been informed of what was being tried to resolve the issue. | F 244 | The Leadership Team will be re-educated by the Administrator or designee on or before 11/4/11 regarding the facility concern process and the expectations of the facility regarding compliance with that process.<br><br>**Monitoring**<br>The NHA/Designee will track and trend results of the resident council concerns as well as resolution and report findings to the QA & A committee monthly. The QA & A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance. The Committee with evaluate the effectiveness of this plan of correction for 3 months and then as necessary. | |
| F 278 SS=D | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement. | F 278 | **F278**<br><br>It is the practice of the facility to ensure that assessment accurately reflect the resident's status, that a registered nurse sign and certify that the assessment it completed, and that each individual who completes a portion of the assessment sign and certify the accuracy of that portion of the assessment.<br><br>**Corrective Action**<br>Resident #68's 7/25/11 quarterly MDS assessment has been modified to reflect the behaviors noted on the July 2011 behavior monitoring form.<br>Resident #70's 8/31/11 quarterly MDS assessment has been modified to reflect the behaviors noted on August 2011 behavior monitoring form.<br><br>**Identification of Others**<br>The MDS Coordinator/designee will complete an audit all residents with an MDS completed in the last 30 days for accuracy of coding in section E of the MDS. Any MDS found with inaccurate information compared to behavior monitoring forms will be modified.<br><br>**Systemic Changes**<br>The Regional Care Management Coordinator/Designee will educate the Resident Care Management Director, Director of Nurses, MDS Coordinator, Social Service Director, and | 11/04/2011 |

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| F 278 | Continued From page 2<br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to ensure the assessment accurately reflected the resident's status for 2 of 19 sample residents (#68, #70). The findings were:<br><br>1. Review of the behavior monitoring form from 7/11/11-7/25/11 showed resident #68 had five episodes of yelling/crying/cursing, three episodes of throwing things, and 10 episodes of hitting other residents and/or staff. Review of the 7/25/11 quarterly MDS assessment revealed the facility failed to code these behaviors.<br><br>2. Review of the 8/31/11 quarterly MDS assessment for resident #70 showed s/he was coded as having no behavior symptoms. However, review of the August 20011 behavior monitoring form showed during the 14-day look-back period the resident had 2 episodes of yelling out and 2 episodes of hitting.<br><br>3. Interview with the MDS coordinator on 9/22/11 at 11:40 AM revealed the areas for mood and behaviors were completed by the social services staff. She was concerned that the "care tracker" where staff looked for this data was not up to date, and this could be the reason for the inaccuracies. | F 278 | Social Services Assistant on MDS accuracy and coding of behaviors in section E utilizing the RAI manual pages E-1 thru E – 6 and pages E-21-E-22.<br><br>The MDS Coordinator/designee will bring completed MDS assessment in draft form to morning meeting Monday through Friday for review with the IDT for accuracy.<br><br>**Monitoring**<br>MDS Coordinator/Designee will track and trend assessment accuracy of section E and report findings to the QA & A committee monthly. The QA & A committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to assure continued compliance monthly for 3 months then re-assess the need for continued monitoring based on compliance. | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. | F 279 | F279<br><br>It is the practice of the facility to ensure use of the results of the assessment to develop, review and revise the resident's comprehensive plan of care, to 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 | 11/04/2011 |

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| F 279 | Continued From page 3<br>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.<br><br>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).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review and staff interview, the facility failed to ensure care plans were developed for 2 of 19 sample residents (#53, #69) and 1 non-sample resident (#81). The findings were:<br><br>1. Review of the medical record for resident #53 showed s/he was admitted to the facility on 8/2/11 and according to the 8/23/11 elopement risk evaluation, the resident was at high risk for elopement. Review of the August 2011 treatment record showed the resident wore a monitoring device on his/her wrist starting on 8/28/11. Review of the resident care plan showed there was no documentation of the resident's elopement behavior or the monitoring device. Interview with the DON on 9/21/11 at 2:17 PM verified there was not a care plan related to the | F 279 | identified in the comprehensive assessment, and the care plan will describe the services that are furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required and any services that would otherwise be required but are not provided due to the resident's exercise of rights including the right to refuse treatment.<br><br>**Corrective Action**<br>An elopement care plan was developed for resident #53 on 9/21/11.<br><br>A care plan was updated to include wandering into other residents' rooms and elopement behavior for resident #81 on 10/07/11.<br><br>A care plan was updated for resident to include elopement behaviors and history of elopement attempt for resident #69 on 10/07/11<br><br>**Identification of Others**<br>An audit of all residents at risk for elopement or wandering has been conducted. Any resident with a risk of elopement or symptoms of wandering into other resident rooms will have a care plan in place or updated.<br><br>**Systemic Changes**<br>The Regional Clinical Director/ designee will educate the Interdisciplinary Team (IDT) completing the care plans upon identification of needs on or before 11/4/11.<br><br>The MDS Coordinator/Designee will complete a random weekly audit of comprehensive assessments to ensure care plans are updated to reflect elopement and wandering risks.<br><br>**Monitoring**<br>Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA & A committee by the MDS Coordinator/Designee. The QA & A committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months. then reassess the need for continued monitoring based on compliance. (KRM) | |

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| F 279 | Continued From page 4<br>elopement behavior, and one needed to be developed.<br><br>2. Review of nursing notes for resident #81 showed on 9/11/11 and 9/12/11 the resident was having behaviors related to wanting to go home and leaving the facility. Observation in the secure unit on 9/21/11 at 1:15 PM showed the resident wandered in and out of other residents' rooms moving their items. Review of a 9/14/11 nursing note showed the resident was hit by another resident and had a black eye from the incident. Review of the resident care plan showed the facility failed to develop a care plan related to the wandering and elopement behaviors. Interview with the administrator in training on 9/22/11 at 10:50 AM confirmed the care plan did not include the wandering behavior.<br><br>3. Review of the 9/19/11 elopement risk review for resident #69 showed s/he was at high risk for elopement. Review of the nurse's notes dated 7/27/11 at 6:35 PM showed the resident had eloped through the doors leading out of the secure unit and was redirected back to the unit. Observation on 9/19/11 at 3:15 PM showed the resident wore a monitoring device on his/her left lower extremity. Review of the resident care plan showed there was no mention of the elopement behavior, or the monitoring device. | F 279 | | |
| F 280 SS=E | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. | F 280 | F280<br><br>It is the practice of the facility to ensure the resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment, and a comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an | 11/04/2011 |

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| F 280 | Continued From page 5<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review, staff interview and observation, the facility failed to update and individualize the comprehensive care plans for 5 of 19 sample residents (#34, #68, #69, #77, #83). The findings were:<br><br>1. Review of the medical record for resident #34 showed s/he had diagnoses which included severe mental retardation and osteoporosis. Review of the 9/9/11 quarterly MDS assessment showed the resident had impairment to the upper and lower extremities on both sides. The assessment also showed the resident was always incontinent of bowel and bladder. Review of the 8/16/11 evaluation for bowel and bladder training showed the plan for management was to check and change. An interview with CNAs #1 and #2 on 9/19/11 at 5:35 PM revealed that the resident was always incontinent of both bowel and | F 280 | interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>**Corrective Actions**<br>The toileting care plan for resident #34 was updated to reflect the current toileting needs and resident #34's range of motion care plan was updated to reflect range of motion for the upper and lower extremities per restorative schedule.<br><br>The behavior care plan for resident #68 was updated to include measurable goals for the reduction in number of episodes per week and to identify triggers to such behaviors. Resident #68's depression, mood and anxiety care plan was updated to include measurable goal.<br><br>The weight loss care plan for resident #69 was updated to include the resident's food preference, diet prescribed and which snacks to offer with a time frame for the snacks.<br><br>The psychoactive medication care plan was updated for resident #77 to reflect the discontinuation of medications due to comfort care. The transfer care plan for resident #77 was updated to reflect the use of a gait belt and level of assist during transfers.<br><br>Resident #83's care plans were updated to include comfort care.<br><br>**Identification of Others**<br>A record review of resident's receiving a quarterly, annual or significant change of condition assessment in the last 30 days was conducted to determine the need for care plan updates, revisions or individualization. All resident's receiving an assessment within this time period will have care plans reviewed by the IDT for revision. | |

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| F 280 | Continued From page 6<br>bladder, and was cognitively unaware. The CNAs further stated the resident was a "check and change," and was not on a toileting schedule. The following concerns with the resident's care plan were noted:<br>a. Review of the resident's toileting care plan last reviewed on 9/1/11 showed the facility failed to update the care plan to reflect the current practice by staff. The care plan called for prompted voiding before meals, after meals, at bedtime and as needed.<br>b. Review of the range of motion care plan last reviewed on 9/1/11 showed the resident was to receive passive range of motion to the upper extremities as tolerated three times a week. The facility failed to address the resident's lower extremities in the plan, or detail the approach for the upper extremities.<br><br>2. Review of the medical record showed resident #68 had diagnoses that included Alzheimer's disease and depression. Review of the behavior monitoring forms for July, August and September 2011 showed the resident had behaviors that included hitting, throwing items, yelling, cursing and elopement attempts. The following concerns were identified;<br>a. Review of the care plan for behaviors last dated 7/27/11, showed there were no measurable goals indicated for the reduction in the number of episodes per week of the identified behaviors. The approaches were to ignore verbal outbursts, and redirect the resident as needed. Further, the care plan showed staff were to be alert to triggers of behavioral episodes. However, the care plan failed to show what those triggers were.<br>b. Review of the care plan last reviewed on 8/29/11 for depression, anxiety and sad mood, | F 280 | **Systemic Changes**<br>The Regional Clinical Director/ designee will educate the Interdisciplinary Team (IDT) completing the care plans upon identification of needs, updating care plans and individualization of care plans on or before 11/4/11.<br><br>The Interdisciplinary team will review telephone orders, the 24 hour report, incident and accidents each business day during the morning business meeting and revise care plans as needed.<br><br>The Interdisciplinary team will review care plans during systems meetings for needed revisions.<br><br>The MDS Coordinator/Designee will verify that care plan revisions have been completed during care conferences quarterly, annually and with change of condition.<br><br>**Monitoring**<br>Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA & A committee by the MDS Coordinator/Designee. The QA & A committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance for 3 months. Then re-assess the need for continued monitoring based on compliance. KRmay | |

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| F 280 | Continued From page 7<br>showed there were no measurable goals indicated for the reduction in the number of episodes per week for altered mood.<br><br>3. Review of the medical record showed resident #69 had diagnoses that included failure to thrive and dementia. Review of the care plan for weight loss last reviewed on 9/20/11 showed approaches in maintaining the resident's weight range included "diet as tolerated, offer preferred foods and offer snacks at night." The plan failed to show any details of the resident's food preference, what the prescribed diet was, or what snacks to offer him/her at what time.<br><br>4. Review of the medical record for resident #77 showed diagnoses including Alzheimer's disease, neuropathy, and diabetes. Review of the end of life care plan showed the resident was placed on comfort care on 9/7/11. Review of the September 2011 medication administration record showed the resident's routine medications were discontinued on 9/6/11; however, review of the care plan for psychoactive medications showed it was not updated to reflect the discontinuation of the medications. In addition, review of the care plan last reviewed on 7/26/11 showed the resident transferred independently with supervision. However, observation on 9/21/11 at 9:30 AM showed the resident was transferred with the use of a gaitbelt and the assistance of two staff members.<br><br>5. Review of the medical record for resident #63 showed the resident was placed on comfort care on 8/10/11. Review of the resident's care plan last reviewed on 8/10/11 showed the information was not updated to identify the resident was receiving | F 280 | | |

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| F 280 | Continued From page 8<br>comfort care. | F 280 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to ensure a coordinated plan of care for 1 of 1 resident (#8) who was receiving hospice services. The findings were:<br><br>Review of the physician's orders for resident #8 showed hospice services were ordered on 9/15/11. Review of the medical record showed a coordinated plan of care between the hospice and nursing home was lacking. Interview with the DON on 9/21/11 at 3:25 PM confirmed that a care plan for hospice had not been coordinated between the two facilities. | F 309 | F309<br><br>It is the practice of the facility to ensure each resident receive and the facility 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.<br><br>**Corrective Action**<br>Resident #8 no longer resides at the facility.<br><br>**Identification of Others**<br>An audit of the Physician orders of current residents was conducted for Hospice Services.<br><br>**Systemic Changes**<br>The DON/designee will obtain Hospice Coordination Care Plans for each resident upon receipt of physician orders to place resident on hospice care.<br><br>Residents receiving Hospice Services will have Coordination of Care Plan reviewed in conjunction with the MDS assessment process on a quarterly basis and the IDT will include Hospice representation.<br>The DON/designee will audit the physician orders Monday through Friday in the morning business meeting for Hospice orders to ensure Hospice Coordination of Plan of Care.<br><br>**Monitoring**<br>Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA & A committee by the MDS Coordinator/Designee. The QA & A committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance for 3 months. then re-assess the need for continued monitoring based on compliance | 11/04/2011 |
| F 323 SS=E | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>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. | F 323 | F323<br>It is the practice of the facility to ensure that the resident environment remains as free of accident | 11/04/2011 |

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| F 323 | Continued From page 9<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, medical record review, and staff interview, the facility failed to ensure resident safety in the secure unit where wandering residents posed a hazard. Two of 7 sample residents (#68, #70) and 4 non-sample residents (#81, #91, #93, #106) were affected. The findings were:<br><br>1. Review of the medical record showed resident #68 had diagnoses that included Alzheimer's disease and depression. Review of the most current MDS quarterly assessment dated 7/25/11 showed the resident was short tempered and easily annoyed. Review of the nurses' notes from 7/17/11-9/19/11 showed nine incidents of resident to resident/staff altercations which included hitting other residents and staff, and yelling and throwing items. Review of incident reports with the DON on 9/21/11 at 3:45 PM showed the resident was involved in 8 reported incidents from 7/25/11-9/19/11. The incident reports showed on 7/25/11 sample resident #70 sustained reddened areas on his/her back after resident #68 pushed him/her while walking in the dining area. On 8/10/11, while in the dining room, resident #68 grabbed the left forearm of resident #91 causing him/her to be "very upset." On 8/20/11 resident #68 hit resident #106 and slapped his/her head and face resulting in a reddened eye. On 9/4/11, while walking down the hallway resident #68 hit resident #70 in the face and started screaming. This incident resulted in the assaulted resident crying and sustaining a reddened face. The | F 323 | hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br>**Corrective Action**<br>The IDT (Interdisciplinary Team) met and reviewed potential triggers for resident #68's behavior and appropriate interventions. An individualized plan of care was developed.<br><br>The IDT (Interdisciplinary Team) met and reviewed potential triggers for resident #81's behavior and appropriate interventions. An individualized plan of care was developed.<br><br>**Identification of Others**<br>A record review of residents residing on the secured unit was conducted reviewing the last 30 days for behavior changes or aggressive episodes. Any identified residents with aggressive episodes were reviewed by the IDT for potential triggers, behavior and appropriate interventions.<br><br>**Systemic Changes**<br>The Medical Director will provide education to the nursing staff on but not limited to the Alzheimer's disease process, behavior, interventions and low stimulus environment on or before 11/4/11.<br><br>Social Services Consultant/designee will in service staff on types of behaviors, identification of behaviors, interventions, redirection techniques and care plan on or before 11/4/11.<br><br>Nursing staff will be in serviced by the Secured Unit Director/Designee on re-directing resident #68 and #81 from locations where other residents may reside when observed entering those areas.<br><br>**Monitoring**<br>Data obtained by way of incident/accident reports will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA & A committee by the Secured Unit Director/Designee. The QA & A committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance for 3 months, then re-assess the need for continued monitoring based on compliance LMay | |

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| F 323 | Continued From page 10<br>following concerns were identified related to prevention and safety:<br>a. Review of the resident's care plan for behavior symptoms last dated 7/27/11 showed staff were to "be alert to triggers of potential evidence of pending behavioral episodes." In addition, staff were to "redirect as needed." The care plan failed to include what type of redirection the resident responded to, or identify any potential triggers. Although review of the behavior monitoring sheets for July and August 2011 showed the resident received medications for behaviors (haldol, Klonopin and Seroquel), medication administration was not included in the care plan as an approach for dealing with behaviors.<br>b. Interview with the DON on 9/21/11 at 3:45 PM revealed the facility had not completed an assessment to determine the triggers that may be causing the resident's behaviors. The DON verified the current interventions included medication and redirecting the resident which were not always effective.<br><br>2. Review of the medical record for resident #81 showed diagnoses that included dementia and mental disorder. Review of a 9/14/11 nurse's note timed 7 PM to 7 AM that while in resident #93's room, resident #81 would not leave and was "punched" in the right eye causing her to fall. The resident did not receive any injury from the fall, but sustained a black eye. Observation during the survey from 9/19/11- 9/22/11 showed the resident's eye was blackened, and the resident continued to wander in the unit. According to a 9/16/11 note, the interdisciplinary team met to discuss a fall; however, there was no mention of the wandering behavior. The following concerns | F 323 | | |

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| F 323 | Continued From page 11<br>were identified:<br>a. Observation on 9/21/11 at 1:15 PM showed resident #81 wandered into 2 other resident rooms on the 500 hall and moved items from room to room. This activity went unnoticed by staff who were busy assisting other residents with dining.<br>b. Review of the care plan showed the wandering behaviors were not addressed.<br>c. Interview with the regional clinical director on 9/22/11 at 9:30 AM revealed the behavior triggers, and care plan interventions needed to be "better" developed.<br>d. Interview with the DON on 9/21/11 at 3:50 PM revealed a plan of care related to wandering behaviors had not been developed. Staff were trained to supervise the resident, and redirect as needed. | F 323 | | |
| F 371 SS=F | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure equipment was cleaned and that surfaces were effectively sanitized in one of two kitchens. The findings were: | F 371 | F371<br><br>It is the practice of the facility to procure food from sources approved or considered satisfactory by Federal, State of local authorities and store, prepare, distribute and serve food under sanitary conditions.<br><br>**Corrective Action**<br>The four ceiling vents above the food prep area were cleaned on 9/24/11.<br><br>Towels used to clean the food prep counter are used with appropriate sanitizer solution.<br><br>**Identification of Others**<br>The dietary manager has reviewed all sanitation audits for the last 30 days to ensure cleaning of any identified areas has been completed.<br><br>**Systemic Changes**<br>Dietary Manager will re-educate dining staff on or before 11/4/11 to include training on sanitation assignments and proper cleaning techniques. | 11/04/2011 |

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| F 371 | Continued From page 12<br><br>1. Observation on 9/19/11 at 1:25 PM and 9/21/11 at 11 AM showed 4 ceiling vents located above food preparation areas in the main kitchen were unclean. There was black dust and grease visible on the vents and the surrounding ceiling tiles. Interview with the dietary manager and registered dietitian on 9/21/11 at 12:05 PM verified the vents were in need of cleaning, and they were not on a cleaning schedule. According to Food Code 2009, U.S. Public Health Service 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. "...(C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris."<br><br>2. Observation of the mid-day food preparation on 9/21/11 at 11:15 AM showed cook #1 was cleaning the counter where food was being pureed. A wet towel was laying on the counter, the cook used this to wipe the counter surface without immersing it into the sanitizer solution. According to Food Code 2009, U.S. Public Health Service: 3-304.14. "...(B) Cloths in-use for wiping counters and other equipment surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under § 4-501.114;" | F 371 | Dietary Manager will complete sanitation checks each business day to ensure proper cleaning and use of sanitizer.<br><br>NHA/Designee to complete random observations of kitchen sanitation on a monthly basis.<br><br>**Monitoring**<br>Data obtained by way of audits/observations will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by the NHA/designee. The QA&A committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months. then re-assess the need for continued monitoring based on compliance. | |
| F 441 SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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. | F 441 | **F441**<br><br>It is the practice of the facility to 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. It will establish an Infection Control Program under which it -- Investigates, controls, and prevents infections in the facility; decides what procedures, | 11/04/2011 |

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| F 441 | Continued From page 13<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of facility infection control program documentation, and staff interview, the facility failed to maintain adequate infection control practices during five random | F 441 | such as isolation, should be applied to an individual resident and maintains a record of incidents and corrective actions related to infections.<br>Prevents spread of infection by when determines that a resident needs isolation to prevent the spread of infection, the facility will isolate the resident.<br>The facility will 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. The facility will require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. And personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>**Corrective Action**<br>Wound care for residents is being provided utilizing proper technique. Equipment used for wound care is being cleaned from dirty to clean surface.<br><br>Staff are sanitizing hands during meal service, between resident contact, and between contact with objects during meal service.<br><br>Volunteers are utilizing appropriate hand washing techniques when entering and exiting resident rooms.<br><br>Staff are utilizing clean technique when assisting residents to change soiled briefs.<br><br>Glucometers are being cleaned with appropriate sanitizing wipes.<br><br>**Identification of Others**<br>An audit of four wound care treatment observation was conducted for proper cleaning of equipment and appropriate use of gloves.<br><br>An audit of four meal observations was conducted for staff using sanitizer between resident service and handling of objects. | |

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| F 441 | Continued From page 14<br>observations. In addition, the facility failed to monitor hand hygiene to ensure an adequate infection control program. The findings were:<br><br>Random Observations:<br><br>1. Observation on 9/20/11 at 2:40 PM showed that during a dressing change for resident #92, RN #1 used scissors to remove the soiled dressings. She proceeded to clean the wound and replace the new dressing without first changing gloves or washing her hands. The RN also failed to clean the scissors before using them to cut the clean dressings. Interview with RN #1 on 9/22/11 at 11:15 AM revealed she should have removed her contaminated gloves and washed her hands before starting to clean the wound and replace the clean dressing.<br><br>2. Observation on 9/19/11 at 4:55 PM showed CNA #3 was assisting residents with their meals. While going from resident to resident, the CNA handled the residents' utensils and dishes, touched the residents' clothing and chairs, and opened food packages. During the interactions with the residents the CNA failed to consistantly sanitize her hands between residents. Interview with the CNA on 9/21/11 at 4:05 PM revealed she was taught to sanitize her hands between each resident contact.<br><br>3. During an observation on 9/21/11 at 11 AM, two non-staff volunteers passed out ice to residents in room numbers 102, 103, 104, 106, 107, 108, 109, 110, 113, 114, and 115. Both volunteers donned gloves before they started, entered each room, and removed the pitchers. Next they placed ice in the pitchers with the same | F 441 | An audit of two volunteer observations was conducted for appropriate hand washing entering and exiting resident rooms.<br><br>An audit of four incontinence care observations was conducted to observe for appropriate clean technique.<br><br>Nursing staff are cleansing glucometers between each resident use with appropriate sanitizing wipes.<br><br>**Systemic Changes**<br>The SDC/Designee will educate the nursing staff and volunteers on cleaning equipment during resident treatment, donning and doffing gloves, washing their hands between delivery of resident meals and contact with objects during meal service, entering and exiting resident rooms, clean technique while providing care, and cleansing glucometers with appropriate sanitizing cleanser on or before 11/4/11.<br><br>DON/Designee will conduct random weekly observations of wound care treatment for cleaning of equipment and appropriate glove use.<br><br>SDC/Designee will conduct random weekly observations of meal service specifically hand washing technique.<br><br>SDC/Designee will conduct random weekly observations of volunteers entering and exiting resident rooms.<br><br>SDC/Designee will conduct random weekly observations of incontinence care specifically clean technique with products.<br><br>SDC/Designee will conduct random weekly observations of cleaning of glucometers.<br><br>**Monitoring**<br>Data obtained by way of audits/observations will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by the SDC/designee. The QA&A committee will evaluate effectiveness of the plan | |

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| F 441 | Continued From page 15<br>scoop, and replaced the pitchers. This was done one room at a time, and the volunteers did not wash or sanitize their hands or change gloves between rooms. During an interview with the infection control coordinator (ICC) on 9/22/11 at 9 AM, she stated that it was unacceptable for staff or volunteers to don one set of gloves and perform tasks in multiple resident rooms without changing gloves and washing or sanitizing their hands.<br><br>4. During an observation on 9/19/11 at 3:15 PM, CNA #1 assisted resident #31 to the toilet. The aide removed the resident's soiled disposable brief, then applied a clean brief. The clean brief came in contact with the resident's dirty shoes when the CNA slid the clean brief over the feet and shoes. During an interview immediately after the observation, the aide stated she got in a hurry and should have removed the resident's shoes when changing briefs.<br><br>5. During an observation on 9/19/11 at 3:50 PM, RN #2 used a glucometer to test resident #59's blood glucose. Immediately afterward, the nurse cleaned the glucometer with alcohol swabs. At 4 PM, the nurse used the same glucometer to test resident #101's blood glucose. Immediately afterward, the nurse cleaned the glucometer with alcohol swabs. During an interview on 9/21/11 at 9:25 AM, the DON revealed that staff are taught to use alcohol swabs or sani-wipes (ammonia based) to clean glucometers. She stated that the facility was unaware that alcohol did not destroy bloodborne viruses.<br>According to recently released guidance by the Food and Drug Administration (FDA) at http://www.fda.gov/MedicalDevices/Productsand | F 441 | based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months. then re-assess the need for continued monitoring based on compliance KRMay | |

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| F 441 | Continued From page 16<br>MedicalProcedures/InVitroDiagnostics/ucm227935.htm (accessed 9/29/11) for cleaning and disinfecting of blood glucose meters, "..The disinfection solvent you choose should be effective against HIV, Hepatitis C, and Hepatitis B virus." Further, "Please note the 70% ethanol solutions are not effective against viral bloodborne pathogens."<br><br>Infection Control Program:<br><br>Review of the facility infection control program on 9/22/11 at 9 AM showed there was no random monitoring of hand hygiene. During an interview with the ICC at that time she verified that the facility failed to complete random monitoring of hand hygiene for staff or volunteers. She further stated that the staff were monitored for hand hygiene during annual competencies. | F 441 | | |
| F 465 SS=D | 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure the floors in the main kitchen and dry food storage room were maintained in a sanitary manner. The findings were:<br><br>Observation on 9/19/11 at 1:25 PM and 9/21/11 at 11 AM showed the floors in the kitchen | F 465 | F465<br><br>It is the practice of the facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>**Corrective Action**<br>The floors in the kitchen were cleaned under the reach in refrigerator, steam table, service counter and food storage room 9/24/11.<br><br>**Identification of Others**<br>An audit was conducted of both all floors in each facility kitchen and food storage area for build up and food debris.<br><br>**Systemic Changes**<br>The Dietary Manager/Designee will educate the Dietary staff on keeping the floors cleaned according to the schedule provided on or before 11/4/11. | 11/04/2011 |

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| F 465 | Continued From page 17<br>underneath the reach-in refrigerators and underneath the steam table and service counter had a build up of dirt and food crumbs. In addition, the dry food storage room floors were not cleaned underneath the shelving. Bits of paper, food, and crumbs were collected under the shelves. Interview with the dietary manager and registered dietitian on 9/21/11 at 12:05 PM verified the floors were in need of cleaning, and there was not any schedule for cleaning under the equipment. | F 465 | The Dietary Manager/designee will provide a schedule for daily cleaning of the floors in the kitchen area.<br><br>The Dietary Manager/designee will provide a schedule for weekly cleaning of the floors in the dry storage areas.<br><br>The NHA/designee will observe the cleaning schedules weekly for 4 weeks then monthly.<br><br>**Monitoring**<br>Data obtained by way of audits/observations will be reviewed and analyzed for patterns and trends and reported monthly to the facility QA&A committee by the NHA/designee. The QA&A committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance monthly for 3 months. then re-assess the need for continued monitoring based on compliance LRMay | |