POC accepted 12/17/10 jc

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

PRINTED: 12/03/2010
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 _____	C 11/18/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: C difficile: Clostridium difficile CNA: Certified Nurse Aide DON: Director of Nursing MDS: Minimum Data Set RN: Registered Nurse 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. This Plan of corrections is the facility's credible allegation of compliance.	
F 226 SS=D	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 review of employee files and policies and procedures, medical record review, and staff interview, the facility failed to implement policies to ensure an allegation of abuse was investigated and reported for 1 of 1 sample resident (#109) with an allegation of abuse. In addition, the facility failed to develop policies to ensure the screening process included an inquiry of the State survey agency CNA registry for 1 of 1 newly hired CNA. The findings were:	F 226	F 226 It is the practice of the facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. 1) Corrective Action: Resident #109 bruises will be (has been) investigated by Don/designee to include staff interviews. Results will be submitted to Ombs and DFS. Identification of Others: dc Current resident records will be reviewed for documentation of bruises for the months of September, October, and November by the DON/designee. Any residents identified for bruising documentation will have an Incident and Accident Report completed by the DON/designee. Monitoring: 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 DON/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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dennis Tigero | TITLE: Administrator | (X6) DATE: 12/13/10

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.

DEC 12 2010 Charges made per phone call with Dennis Tigero, Administrator on 12/7/10 @ 8:04 am

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: SYFQ11 Facility ID: WY0028 If continuation sheet Page 1 of 26

Office of Healthcare Licensing and Surveys

Jackie Conklin

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4306 S POPLAR CASPER, WY 82601

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F 226	Continued From page 1 1. Review of the facility's policy "Abuse & Neglect Prohibition" (dated February 2010) showed "...the facility will conduct an investigation of any alleged abuse/neglect, injuries of unknown origin, or misappropriation of resident property in accordance with state law,...the facility will report such allegations to the state,...the facility will report all allegations and substantiated occurrences of abuse, neglect, injuries of unknown origin, and misappropriation of property to the state agency and law enforcement officials as designated by state law." The following concerns were identified: a. Review of nursing notes showed on 9/15/10 resident #108 reported that the bruises on his/her hands and wrists were caused by staff pulling on him/her in the shower. Review of a nursing communication to the physician dated 9/15/10 revealed both of the resident's hands appeared reddish, purplish, dark blue from fingers to past the wrists. Nursing further documented "resident reports it is from staff pulling on [him/her]." Review of the a physician progress note and orders dated 9/22/10 showed the resident had multiple ecchymoses (bruises) on the hands and leg "likely from impact." b. During an interview on 11/17/10 at 6 PM, the administrator stated he did not have any information related to that allegation of abuse. c. During an interview on 11/18/10 at 8 AM, the DON stated nursing assessed the resident at the time, and didn't think the injuries were caused by staff. The DON stated the facility did not consider it an allegation of abuse, therefore it was not reported nor investigated as an allegation of abuse. 2. Review of the employee file for CNA #1	F 226	Corrective Date: 12/31/10 Systemic Changes: Residents identified with bruising on the 24 hour report sheets (which are completed by the nursing staff) will also have an Incident and Accident form completed by the Unit Coordinator/designee. The Incident and Accident Report will be reviewed by the Inter-Disciplinary team in morning meeting Monday through Friday. DON/designee will monitor the Incident and Accident Report sheets Monday through Friday, and report to monthly QA&A committee. DON or designee will educate licensed nurses on completing incident reports for bruises of known and unknown origin on or before 12/31/10. 2) Corrective Action: Certified Nursing Assistances at this facility have completed the Abuse screening registration with the Wyoming State Board of Nursing. The Human Resource Director/designee will verify the completion of the registration process. Identification of Others: All currently employed Certified Nursing Assistants' files will be audited by the Human Resource Director/designee for verification of registration with the Wyoming State Board of Nursing for Abuse screening registration. Any Certified Nursing Assistants not registered will become registered. Systemic Changes: All newly hired Certified Nursing Assistants will have registration for Abuse screening verified by the Human Resource Director/designee upon employment.	12/31/10

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F 226	Continued From page 2 revealed she was hired on 9/28/10. Further review of the employee file showed no evidence the State survey agency CNA registry was checked to ensure there was no findings related to abuse. During an interview on 11/18/10 at 7:55 AM, the human resources director confirmed the facility did not check the State survey agency CNA registry for any findings. Review of the facility's "Abuse & Neglect Prohibition" policy (dated February 2010) revealed the procedures for screening of staff did not include checking the State survey agency CNA registry for findings related to abuse.	F 226	Monitoring: 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 DON/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	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 11 of 11 residents (#42, #46, #60, #76, #78, #79, #80, #91 #93, #107, #110) who received pureed textured diets were treated in a dignified manner related to meal options. In addition, the facility failed to ensure 1 of 20 sample residents (#74) was dressed by staff in a way to maintain the resident's dignity. The findings were: 1. During observation of the mid-day meal preparation on 11/17/10 at 10:50 AM, cook #2 prepared pureed food for the residents. The main menu items were pureed; however, a second	F 241	F 241 It is the practice of the facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Corrective Action: Residents #'s 42, 46, 60, 76, 78, 79, 80, 91, 93, 107, and 110 will be offered a Puree alternative meal. Education of dietary staff to have an alternative pureed meal was given by the Dietary Manager/designee on or before 12/31/10. Identification of Others: Review of dietary orders will be completed by the Dietary Manager/designee for residents ordered a puree diet. Systemic Changes: All residents identified as receiving a pureed diet will have an alternative choice made available to them by the dietary staff. The Dietary Manager/designee will monitor this Monday through Friday.	

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F 241	Continued From page 3 option that was prepared was not pureed. Interview with the dietary manager on 11/17/10 at 12:05 PM revealed there were eleven residents (#42, #46, #50, #76, #78, #79, #80, #91 #93, #107, #110) who had pureed diets, and they were not usually provided an alternative or second option. She stated what was pureed was dependent on the cook. Interview with cook #2 at that time revealed 8 of the 11 pureed diets were served in the secure unit. Further interview with the cook revealed if they provided a second pureed option, there would not be room for it on the steam table in the secure unit service area. During the mid-day meal in the secure unit on 11/16/10 at 12:01 PM, a CNA said "she's a puree...she doesn't get a choice." Observation of the mid-day meal service on 11/17/10 from 11:55 AM to 12:35 PM revealed residents who did not have pureed diets were offered an option of lasagna or pork roast as the main dish, whereas the residents with pureed diets were not treated with the same respect, pureed lasagna was their only option. 2. Review of the 8/17/10 annual MDS assessment revealed resident #74 required extensive assistance with dressing. Observation during the tour in the secure care unit (SCU) on 11/15/10 at 3:55 PM revealed the resident wore socks without shoes. The resident's socks did not match. Observation on 11/16/10 at 7:30 AM and throughout the day revealed the resident wore socks without shoes. The resident's socks again did not match (one white and one grey). During an interview on 11/18/10 at 8:40 AM, the SCU manager stated the resident required staff assistance for dressing. She stated she was unsure why the resident wore mismatched socks	F 241	Monitoring: 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 Dietary Manager/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. Corrective Date: 12/31/10 Corrective Action: Resident #74 will be clothed with matching socks. Nursing staff will be educated by SDC/designee on the importance of but not limited to the proper choice of clothing for residents requiring extensive assistance to ensure residents dignity. Done on or before 12/31/10. Identification of Others: An audit will be completed by the DON/designee of the Caretracker system for residents requiring extensive assist with dressing. Identified residents Kardex's will be updated by DON/designee to reflect present level of extensive assistance to enable staff to be aware of each resident's needs. Systemic Changes: Kardex's will be updated quarterly by the MDS nurse/designee following the OBRA schedule for assessment dates. New residents' Kardex's will be completed upon admission by the admitting nurse/designee and updated by the MDS nurse/designee following the PPS schedule for assessment dates.	12/31/10

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POPLAR LIVING CENTER	4300 S POPLAR CASPER, WY 82601

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F 241	Continued From page 4 for two days.	F 241	Residents' clothing will be monitored Monday through Friday by use of the assigned Ambassador/designee. Monitoring: Data obtained by way of audits will be reviewed and analyzed for pattern and trends and reported monthly to the facility QA&A committee by DON/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. Corrective Date: 12/31/10 F273 It is the practice of the facility to conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. Corrective Action: Residents # 9 and 57 Admission MDS's have been completed. Identification of others: All residents newly admitted to the facility from 11/1/10 forward Systemic Changes: RCMD and MDS Coordinator will be in serviced on assessment timeliness by RCD/designee. RCMD will review MDS schedule Daily Monday thru Friday in morning meeting with IDT. RCMD will review validation report weekly with NHA. RCMD will email validation report weekly to RCMC.	12/31/10
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure an admission assessment for two of two newly admitted sample residents (#9, #57) was completed within 14 days of admission. The findings were: Review of the medical record for resident #9 showed the resident was admitted to the facility on 11/3/10. Review of the medical record for resident #57 showed the resident was admitted to the facility on 10/21/10. Further medical record review revealed no admission MDS assessments were found for either of these residents. During an interview with the MDS coordinator on 11/18/10 at 9:05 AM, she stated the admission MDS assessments for residents #9 and #57 were past due. According to the September 2010 MDS RAI Version 3.0 Manual, page 2-15, an admission MDS assessment is required on the 14th calendar day of the resident's admission	F 273		

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F 273	Continued From page 5 (admission date + 13 calendar days).	F 273	Monitoring: 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 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. Corrective Date: 12/31/10 F 276 It is the practice of the facility to assess a resident using the quarterly review instrument specified by the state and approved by CMS not less frequently than once every 3 months. Corrective Action: Quarterly MDS was completed for resident # 74. Identification of Others: All residents due for a quarterly MDS assessment 11/1/10 forward Systemic Changes: RCMD and MDS Coordinator will be in serviced on assessment timeliness by RCD/designee. RCMD will review MDS schedule daily Monday thru Friday in morning meeting with IDT. RCMD will review validation report weekly with NHA. RCMD will email validation report weekly to RCMC.	12/31/10
F 276 SS=D	483.20(a) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure a quarterly MDS assessment was completed once every three months for 1 of 18 sample residents with quarterly assessments. The findings were: According to the Long Term Care Facility Resident Assessment Instrument User's Guide, Version 3.0, September 2010, page 2-30, "...The ARD [assessment reference date] must be not more than 92 days after the ARD of the most recent OBRA assessment of any type." Review of the medical record for resident #74 showed the last MDS assessment was an annual, with an ARD of 8/5/10. During an interview on 11/17/10 at 3:08 PM, the DON stated the next quarterly MDS was past due. She stated they "have gotten behind."	F 276		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281		

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F 281	Continued From page 6 Based on observation, medical record review and staff interview, the facility failed to meet professional standards for 2 of 20 sample residents (#28, #106) and non-sample resident #97. The findings were: 1. On 10/5/10 resident #28 returned to the facility following a brief admission to the hospital. Two separate concerns were identified: a. According to the 2/9/10 admission MDS assessment and the 9/22/10 significant change MDS assessment, the resident's cognitive skills for daily decision making were consistent and reasonable. Medical record review revealed the resident and physician had signed the Advanced Directives/Medical Treatment Decisions Acknowledgement of Receipt indicating his/her wish of a "Full Code." However, review of the physician transfer orders dated on 10/5/10 revealed an order for "Do Not Resuscitate." During an interview on 11/17/10 at 6 PM, this discrepancy was brought to the attention of the DON. Further interview with the DON on 11/18/10 at 8:05 AM revealed she visited with the resident on the evening of 11/17/10 and the resident had verbalized his/her wish to continue full code status. On 11/18/10 at 10:10 AM the DON stated the facility should have verified this discrepancy when the resident returned to the facility on 10/5/10. b. Review of the blood glucose tracking/sliding scale insulin administration record showed the facility had been monitoring the resident's blood glucose levels since his/her return to the facility on 10/5/10 with no current physician order for blood glucose monitoring. During an interview with the DON on 11/18/10 at 10:10 AM she stated nursing staff should have reviewed all orders upon the resident's return and	F 281	Monitoring: 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 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. Corrective Date: 12/31/10 F281 It is the practice of the facility to ensure that services provided or arranged by the facility must meet professional standards of quality. Corrective Action: Resident #28 DNR status was reviewed with resident on 11/17/10 and Consents to uphold resident's wishes were obtained. Identification of Others: Re-admitted Residents for September, October, and November charts will be reviewed by DON/designee for Code status. All residents identified with code status change after re-admission will be addressed by DON/designee. Systemic Changes: Nursing staff will be educated by DON/designee to obtain code status consents upon re-admission to verify present code status. Done on or before 12/31/10. IDT will review all re-admitted residents' records for accuracy of code status in morning meeting Monday thru Friday.	

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F 281	Continued From page 7 attained clarification from the attending physician if discrepancies were found. Review of Smith, Duell, and Martin in "Clinical Nursing Skills Basic to Advanced Skills," 7th Edition, 2008, revealed that if an order is "questionable for any reason, the physician must be notified for clarification." 2. Observation on 11/16/10 at 11:15 AM revealed RN #3 failed to clean the top of an open vial of insulin prior to withdrawing the medication administered to resident #97. According to Elkin, Perry and Potter, "Nursing Interventions and Clinical Skills," "Administration of Injections", chapter 17 and "Administering Intravenous Medications", chapter 27, Fourth Edition, Mosby, Inc., 2007: Intravenous ports and vial tops should be cleansed with sterile 70% isopropyl alcohol or other approved antiseptic swab. This should be done with friction and the port allowed to dry before accessing. 3. Review of the medical record for resident #105 revealed a physician's order dated 10/25/10 that directed staff to collect a stool specimen for C. difficile if the resident continued to have watery bowel movements. According to the documentation in the nurses notes, and nursing daily skilled summary, staff noted the resident had diarrhea on 11/4/10, 11/5/10, 11/6/10 and 11/8/10. Interview with the resident on 11/16/10 at 7:25 AM revealed s/he "still" had problems with "runny" bowel movements "every now and then." During the interview on 11/18/10 at 11:25 AM the DON verified the specimen had not been collected in accordance with the physician's order. The DON further stated the failure to obtain the specimen was not an acceptable standard of practice for the facility.	F 281	Monitoring: 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 DON/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 Corrective Date: 12/31/10 Corrective Actions: Resident # 28 Blood Glucose monitoring order was verified with the physician. Identification of Others: Residents receiving Blood Glucose monitoring. Records will be reviewed by DON/designee for accurate orders. Any identified inaccuracies will be clarified with attending physicians by DON/designee Systemic Changes: New Admission orders will be reviewed by IDT in morning meeting Monday thru Friday. Any inaccuracies will be corrected by the Unit Coordinator/designee. Monitoring: 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 DON/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.	
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309	Corrective Date: 12/31/10	

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F 309 SS=D	Continued From page 8 HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and medical record review, the facility failed to ensure pain assessments and treatments were effectively provided prior to wound care for 1 of 11 sample residents (#23) who had pain. The findings were: Review of the skin condition records for resident #23 showed s/he had multiple pressure and non-pressure wounds on the lower extremities. An interview with the resident on 11/16/10 at 8:20 AM revealed s/he experienced pain with wound treatments. The resident stated it depended on which staff were working as to whether pain medication was offered prior to the dressing changes. The resident further revealed s/he sometimes refused pain medication, thinking the pain would not be that bad. Review of the physician's order dated 8/9/10 showed the resident had an order for morphine sulfate 10-20 milligrams (mg) (0.5-1 ml) solution every 2 hours as needed for pain. Interview with RN #1 prior to wound treatment on 11/17/10 at 3:07 PM revealed the resident was pre-medicated about 30 minutes prior with morphine sulfate 20 mg/.05	F 309	Corrective Action: Nurses educated by SDC/designee on proper cleaning of top of insulin vials prior to withdrawing the medication. Identification of Others: Review of Medication Administration Records for all Residents receiving insulin by DON/designee. Systemic Changes: New Nurses and licensed nurses will be educated on but not limited to the proper cleaning of the top of the insulin vials prior to withdrawing the medication during orientation by SDC/designee. Done on or before 12/31/10. Random Weekly audits of nurses administering insulin for proper cleaning of vials by SDC/designee. Monitoring: 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 DON/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 Corrective Date: 12/31/10 Corrective Actions: Resident # 105 C-diff order was discussed with physician. No new orders given. Nurses were educated on importance of but not limited to obtaining ordered labs by SDC/designee. Done on or before 12/31/10.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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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 _____	C 11/18/2010

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

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F 309	Continued From page 9 ml solution. During observation of the dressing change at that time revealed the resident cautioned the two nurses to be careful multiple times when working on the pressure ulcer on his/her right heel, the resident stated "touching it hurts." While working on this wound, the resident grimaced and yelled out "oh!" When asked by the RNs if the pain medication was working, the resident stated s/he didn't think so, s/he thought maybe it was a "placebo." The following concerns were identified related to the pain assessment and treatment for this resident: a. Review of the pain evaluation for this resident showed it was dated 8/4/10, and did not address any wounds or dressing changes. A new evaluation had not been completed since the development of the pressure wounds on each of the residents heels, which according to review of the weekly pressure ulcer record was documented with an onset date of 8/30/10. b. On the following dates in October and November 2010, the resident's wounds were assessed by the wound team, and pain related to the wounds was identified by a check marked box then referring to a pain management flow sheet: 10/6, 10/12, 10/19, 10/26, 11/2, 11/9. Review of the pain management flow sheet for October 2010 showed it was blank. Review of the pain management flow sheet for November 2010 showed there was one entry recorded on 11/13/10 revealing the resident received pain medication (morphine sulfate) which according to the flowsheet was effective in decreasing the lower extremity pain. There was no further information on the pain management flow sheets to show what was done for the identified pain during wound care. In addition, review of the medication administration records (MARs) for October and November 2010 also showed the	F 309	Identification of Others: Medication Administration Records will be reviewed for residents receiving antibiotics by DON/designee. Identified residents will be added to Lab Audit Sheets to ensure follow up with labs per Physician orders by DON/designee. Systemic Changes: Review of 24 hour reports by IDT in morning meeting Monday thru Friday for any antibiotic or labs reported. New nurses will be educated during orientation by SDC/designee on importance of obtaining ordered lab requests. Done on or before 12/31/10. Unit Coordinators will utilize the Lab Audit sheets to ensure follow up on ordered labs. Monitoring: 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 DON/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. Corrective Date: 12/31/10 F309 It is the practice of the facility to ensure 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.	12/31/10

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F 309	Continued From page 10 only time PRN pain medication was administered was on 11/13, and there were no refusals documented. Interview with the DON on 11/18/10 at 10:50 AM verified the resident needed a new pain evaluation related to his/her current wound condition. In addition, the DON revealed the resident needed to be assessed for pain prior to dressing changes, and this needed to be documented on the pain flowsheets. Without this record, she verified it was difficult to show that pain was being addressed by the nursing staff, or if the resident refused the pain medication.	F 309	Corrective Action: Resident #23 pain assessment was updated on 11/18/10. Nurses educated on but not limited to the importance of documentation of refusal of pain medication prior to treatment. Done on or before 12/31/10. Identification of others: Residents Treatment Records will be reviewed to identify all residents receiving wound care by the DON/designee. Systemic Changes: Nurses will be educated by SDC/designee on but not limited to the importance of offering ordered pain medication to residents prior to wound care or treatment and proper documentation of administration, effectiveness or refusal of medication. Done on or before 12/31/10. Unit Coordinators/designee will monitor residents receiving wound care once weekly for proper documentation and use of pain medication prior to wound care. Unit Coordinator or designee will update pain assessments on all residents receiving treatment for pressure or stasis ulcers. This will be done on or before 12/31/10 Monitoring: 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 DON/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. Corrective Date: 12/31/10	12/31/10
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and medical record review, the facility failed to ensure 1 of 20 sample residents (#28) had the assistive device needed to maintain the resident's mobility and transferring skills. The findings were: Review of the the 9/22/10 significant change MDS assessment and corresponding care plan for resident #28 showed s/he required extensive assistance with transfers. Review of the medical record showed the physical therapist determined a trapeze was not effective in increasing the resident's ability to move more independently in and out of bed; therefore it was replaced with a	F 311		

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POPLAR LIVING CENTER	4805 S POPLAR CASPER, WY 82601

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F 311	Continued From page 11 transfer pole in October 2010. Interview with the resident on 11/16/10 at 7:05 AM revealed the transfer pole "broke" five days earlier and was removed. During the interview the resident revealed the transfer pole made it possible for him/her to transfer independently and s/he was concerned because it had not been repaired. S/he further stated that when s/he used the transfer pole, staff only had to stand by during transfers, but without the pole sometimes they had to "pull on" him/her. Interview with the DON on 11/17/10 at 5:15 PM revealed she did not know the transfer pole was no longer in the the resident's room. Interview with the physical therapist and two certified occupational therapy assistants on 11/16/10 at 8:30 AM, revealed the resident was unsteady and needed to have a staff person present during all transfers, however the transfer pole was needed for the resident to complete transfers more independently and safely. They further stated they did not know when or if the transfer pole was going to be repaired. Interview with the maintenance director on 11/18/10 at 8:45 AM revealed he had no plans to repair the transfer pole because he had not been instructed to do so. Interview with the DON on 11/18/10 at 11:35 AM revealed the issues regarding the transfer pole for the resident had not been addressed due to poor communication within the departments and disciplines. Observation on all days of the survey (11/15/10 through 11/18/10) confirmed the resident did not have a transfer pole.	F 311	F 311 It is the practice of the facility to ensure a resident is given the appropriate treatment and services to maintain or improve his or her abilities. Corrective action: Resident # 28 Transfer pole was replaced after IDT review in morning meeting. 11/26/10 Identification of others: Facility will be Audited for residents using transfer poles or trapeze to enable transfers by DON/designee. Systemic Changes: Review of 24 hour report sheet by IDT Monday thru Friday in morning meeting for transfer poles or trapeze issues. Utilization of assigned Ambassadors to monitor equipment Monday thru Friday for residents identified as utilizing transfer poles or trapeze Monitoring: 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 DON/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. Corrective Date: 12/31/10	12/31/10
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	F 312	F 312 It is the practice of the facility to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	

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POPLAR LIVING CENTER	4305 S POPLAR CASPER, WY 82601

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F 312	Continued From page 12 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident, family, and staff interview, the facility failed to ensure bathing assistance was provided in a timely manner for 12 of 21 sample residents (#9, #21, #23, #28, #29, #55, #57, #72, #87, #105, #109, #112) who required such assistance. In addition, the facility failed to provide adequate incontinence care for 5 of 11 residents (#25, #28, #59, #65, #71) observed who required such assistance. The findings were: In regard to bathing assistance: 1. Observations from 11/15/10 through 11/17/10 showed resident #57 had a noticeable and offensive body odor. Review of the activities of daily living (ADL) reports from 10/28/10 through 11/16/10 showed the resident had no shower/bath for those 20 days. In addition, review of the entire medical record showed an assessment to determine the resident's level of assistance for bathing was lacking. 2. Review of the 10/21/10 admission MDS assessment showed resident #21 was totally dependent for bathing and required extensive staff assistance. Review of the ADL reports showed the resident had no shower/bath from 10/21/10 through 11/9/10 (20 days). 3. Review of the ADL report from 10/28/10 to 11/16/10 showed resident #23 received his/her last bath/shower on 11/4/10 which required	F 312	Corrective Actions: Resident #57 was bathed on 12/4/10. Refusals documented on 11/19/10 x 2 attempts, and 11/29 10. Resident #21 was bathed on 11/22/10 and 12/2/10 and 12/4/10. Refusal documented on 11/24/10 Resident #23 was bathed on 11/22/10, 11/29/10, 12/2/10 and 12/6/10 Resident #28 was bathed on 11/18/10, 11/22/10, 11/29/10, 12/2/10, and 12/5/10. Resident # 29 was bathed on 11/28/10 and 12/3/10. Refusals documented on 11/20/10 x 2 attempts, 11/25/10 and 12/05/10. Resident #55 was bathed on 11/21/10, 11/24/10 and 12/1/10. No refusals documented. Residents care plan updated to reflect level of assistance. Resident # 9 was bathed on 11/19/10, 11/23/10, and 12/1/10. Refusal documented on 12/6/10. Residents care plan updated to reflect level of assistance. Resident # 72 was bathed on 11/18/10, 12/2/10, 12/6/10, and 12/7/10. No refusals were documented. Resident #87 was bathed on 11/18/10, 11/23/10, and 12/2/10. Refusal on 11/20/10 documented. Resident # 105 bathed once weekly per resident interview. No baths or refusals documented. Resident # 109 Bathed on 12/1/10. Refusal on 11/19/10 documented. Resident # 112 no longer at the facility, deceased. Family concerns or complaints are addressed during IDT in morning meetings. Unable to verify mentioned family members concern, without concern form	

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F 312	Continued From page 13 extensive assistance. The report showed no further baths/showers had been provided during the 12 days since that time. Interview with the resident on 11/17/10 at 10:15 AM revealed it was "a couple of weeks ago" since s/he was showered or bathed. The resident in a concerned tone asked, "Why can you tell?" 4. Review of the 10/26 -11/16/10 ADL reports showed resident #28 did not receive a shower/bath during that 22 day time period. Interview with the resident on 11/16/10 at 7:06 AM revealed sometimes the resident told staff s/he could "wait" until the next scheduled bath day because staff appeared to be too busy or short of help to do it that day. 5. According to the care plan, updated 10/21/10, resident #28 required extensive assistance with showers and personal hygiene, but the resident sometimes refused. Further review of the care plan revealed no additional interventions, alternatives, or approaches to ensure the resident received personal hygiene care. Review of the 10/26 -11/16/10 ADL reports showed the resident received two showers during the three week time period. 6. Review of the 10/7/10 admission MDS assessment showed resident #55 was totally dependent for bathing. Review of the ADL reports showed the resident had no shower/bath for 18 days from 10/26/10 through 11/12/10. 7. Review of the ADL reports showed resident #9 had no shower/bath for 13 days from 11/4/10 through 11/16/10. Review of the entire medical record showed staff did not assess the resident to determine how much assistance from staff was	F 312	Nursing staff re-educated on importance of documentation of bathing or refusal of bathing by DON/designee. Done on or before 12/31/10 Identification of others: Review of documentation for residents requiring assistance with bathing will be completed by DON/designee. Systemic Changes: DON/designee will present list of residents needing baths to IDT at morning meeting Monday thru Friday. Residents assigned ambassador will monitor bathing to ensure compliance Monday thru Friday. Weekend manager will insure compliance on Saturday and Sunday. Social Services/designee will review bathing during resident council to determine if residents are being offered baths. Monitoring: 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 DON/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. Corrective Date: 12/31/10	

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F 312	Continued From page 14 required for bathing. 8. Review of the 9/30/10 quarterly MDS assessment revealed resident #72 required total assistance for bathing. According to the ADL report, the resident went from 10/26/10 until 11/4/10 without bathing (8 days). Review of the behavior detail report showed no refusals during that time. 9. According to the 9/26/10 quarterly MDS assessment, resident #87 required total assistance for bathing. Review of the ADL report revealed no baths or showers were given for 21 days (10/26/10 through 11/16/10). There were no documented refusals on the behavior detail report during that time. 10. According to the 10/16/10 comprehensive MDS assessment, resident #105 required staff assistance to bathe. Review of the 10/26-11/16/10 ADL reports showed the resident received a bath one time during the three week time period. Further review of the ADL reports revealed no documentation regarding resident refusals or other reasons the resident did not receive a bath. 11. Review of the 8/18/10 quarterly MDS assessment showed resident #109 required total assistance with bathing. Review of the ADL report documentation showed no bath or shower was given from 10/26/10 through 11/16/10 (21 days). Review of the behavior detail report showed no refusals of bathing during that time. 12. Review of the 7/22/10 annual MDS assessment showed resident #112 required extensive assistance with bathing and personal	F 312	Corrective Actions: Resident # 25 receiving proper perineum care with each incontinent episode. Resident # 28 receiving proper perineum care with each incontinent episode. Resident # 65 receiving proper perineum care with each incontinent episode. Resident # 59 receiving proper perineum care with each incontinent episode. Resident # 71 receiving proper perineum care with each toileting episode. Identification of Others: Review of charting to identify residents with assistance needs for toileting and personal hygiene to be completed by DON/designee. Systemic Changes: Nursing and Therapy staff will be educated on proper perineum care by SDC/designee. Done on or before 12/31/10 Random weekly observation audits of perineum care will be completed by SDC/designee. Monitor 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 DON/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. Corrective Date: 12/31/10	12/31/10

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F 312	Continued From page 15 hygiene care due to cognitive impairment prior to admission to the hospital on 10/22/10. Review of the 9/2/10 to 10/21/10 ADL reports showed the resident received a bath four times during the forty-nine day time period. During an interview on 11/22/10 at 5:45 PM a family member revealed sometimes during visits the resident's appearance and odors caused the family to be concerned about lack of appropriate hygiene/bathing. 13. Confidential interviews with twenty residents during the course of the survey from 11/15/10 through 11/18/10 showed each did not receive showers/baths in a timely manner, with over one week between baths being the norm. 14. During a confidential interview on 11/17/10 at 8 PM, a family member stated s/he had noticed some residents with body odor. 15. During an interview on 11/16/10 at 8:17 PM, the DON stated baths and showers were documented in the ADL report in the computer. She stated refusals should be documented. On 11/17/10 at 11:10 AM, CNA #2 stated bathing was documented on the ADL report, and refusals were documented on the behavior detail report. The CNA stated bathing didn't always happen "...sometimes because of staffing, sometimes because of behaviors." In regard to incontinence assistance: 1. During an observation of resident #26 on 11/16/2010 at 8 AM CNA #3 failed to clean the resident's anterior perineum after found to be incontinent of urine. Review of the 9/29/10 quarterly MDS assessment revealed the resident	F 312		

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F 312	Continued From page 16 required extensive assist with hygiene. 2. During observation of resident #28 on 11/16/2010 at 8:50 AM, therapy staff #1 failed to clean the resident's anterior perineum after the resident was found to be incontinent of urine. Review of the 9/22/10 significant change MDS assessment revealed the resident required extensive assist with hygiene. 3. Review of the 9/8/10 quarterly MDS assessment showed resident #65 required extensive assistance from staff for toileting. During an observation on 11/16/10 at 7:26 AM, the resident was in bed and incontinent of urine. At that time CNAs #4 and #5 assisted the resident, and CNA #4 cleansed the resident's perineum front and back. However, the CNA did not cleanse the lower back or thighs where urine came in contact with the skin. During an interview with CNA #4 immediately after the observation, she said that all areas of the resident's skin that came in contact with urine should have been cleansed. 4. Review of the 10/21/10 quarterly MDS assessment showed resident #59 required extensive assistance from staff for toileting. During an observation on 11/16/10 at 7:35 AM, the resident was in bed and incontinent of urine. At that time CNA #5 assisted the resident to the bathroom. CNA #5 cleansed the resident's perineum front and back, but did not cleanse the lower back or thighs where urine came in contact with the skin. During an interview with CNA #5 immediately after the observation, she said that all areas of the resident's skin that came in contact with urine should have been cleansed.	F 312		

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F 312	Continued From page 17 5. Review of the 7/21/10 significant change MDS and corresponding care plan for resident #71 revealed the resident required extensive assistance with toileting and personal hygiene care. Observation on 11/16/10 from 8:30 AM, revealed CNA #8 assisted the resident to the bathroom. After the resident voided, observation of the personal hygiene care provided by the CNA revealed she only cleansed the resident's posterior area. Interview with the CNA as she assisted the resident from the bathroom confirmed she had not cleansed the resident's perineal area.	F 312		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced	F 425	F 425 It is the practice of the facility to provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in 483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. It is the practice of the facility to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. It is the practice of the facility to employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	

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	535024	A. BUILDING _____ B. WING _____	C 11/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR LIVING CENTER	4306 S POPLAR CASPER, WY 82601

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F 425	Continued From page 18 by: Based on observation and staff interview, the facility failed to ensure expired medications were not available for use in two of two medication storage rooms. In addition, medications in one of four medication carts was found with inappropriate labeling. The findings were: Observation in the first medication room on 11/17/10 at 6 PM revealed three phenadoz suppositories available for use in the refrigerator with an expiration date of 10/09. Observation in the second medication room on 11/17/10 at 6:10 PM revealed the following expired medications available for use: vitamin B 50 milligrams (mg) expired 6/10; vitamin B 100 mg expired 9/10; and heparin flush expired 10/09. Observation of the first medication cart on 11/17/10 at 6:20 PM revealed one syringe labeled "promethazine 25 mg/ml" and a second syringe labeled "promethazine/lipoderm." Interview with RN #4 during the observation confirmed the medication was not properly labeled and was uncertain why it was in the medication drawer. Interview with the DON on 11/17/10 at the time of the observations confirmed the medications were expired and should have been discarded. According to "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Dull, and Martin, Seventh Edition, page 606, "Unless contamination is suspected the Centers of Disease Control and Prevention (CDC) recommends the vial be discarded either when empty or on the expiration date set by the manufacture." Review of the facility's policy and procedures entitled, "Medication Labels" policy #5135, revealed "Floor stock medications are labeled as "floor stock or house supply" and kept in the original manufacturer's container with the expiration date and lot number clearly evident."	F 425	Corrective Action: Phenadoz suppositories from 1st medication room removed. Vitamin B 50 mg, Vitamin B 100mg and Heparin flush from 2nd medication room removed. Syringe labeled Promethazine 25 mg/ml and syringe labeled Promethazine/Lipoderm from medication cart removed. Identification of Others: Review for further expired medications in medication rooms and carts to be completed by DON/designee. Done on or before 12/31/10 Any identified medications will be immediately removed from said areas. Systemic Changes: Monthly audit of medications in medication rooms and medication carts for expired medications to be completed by DON/designee. SDC/designee to re-educate nursing staff on the importance of but not limited to removing expired medications from medication rooms and carts. Done on or before 12/31/10 Monitoring: Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to facility QA&A committee by DON/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. Corrective Date: 12/31/10	12/31/10

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F 425	Continued From page 19 "The provider pharmacy permanently affixes labels to the outside of prescription containers." 493.60(b), (d), (e) DRUG RECORDS,	F 425	F 431 It is the practice of the facility to 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	
F 431 SS=D	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 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.	F 431	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 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 1970 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored in minimal and a missing dose can be readily detected. Corrective Action: Humalog 100 U, Novolin N – 100, Pneumococcal vaccine and Tuberculin vials were removed from the 1st medication room. Haloperidol vial was removed from the 2nd medication room. Identification of others: DON/designee will review for further opened non-dated/initialed vials in the medication room and medication carts. Any identified medications will be removed from the medication rooms and carts.	

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F 431	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation and staff review, the facility failed to ensure open multidose vials stored in two of two medication storage rooms were dated and initialed when opened. The findings were: Observation in the first medication room on 11/17/10 at 6 PM revealed the following medications were opened but not dated and initialed: one vial of Humalog 100 U, Novolin N-100, pneumococcal vaccine, and tuberculin. Each was available for use. Observation in the second medication room on 11/17/10 at 6:10 PM revealed an open multidose vial of haloperidol. The vial was not dated or initialed and was available for use. Interview with the DON during the observations confirmed the medications should have been dated and initialed. According to "Clinical Nursing Skills Basic to Advanced Skills" by Smith, Duell and Martin, seventh edition, page 605, "If multi-use vials are opened, they should be marked with the date and time the container is entered and nurse's initials".	F 431	Systemic Changes: Weekly random audits of medication rooms and carts by SDC/designee to verify dates and initials are on all open vials of medication. Monthly audits of opened medication vials in medication rooms and carts by DON/designee. Re-education of nurses by SDC/designee on importance but not limited to dating and initialing vials upon opening as well as removing and replacing vials that are not dated or initialed. Done on or before 12/31/10 Monitoring: 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 DON/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. Corrective Date: 12/31/10	12/31/10
F 441 SS=E	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,	F 441	F 441 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 (a)Infection Control Program It is the practice of the facility to 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.	

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F 441	Continued From page 21 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 (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 random observations of care, medical record review, and staff interview, the failed to ensure staff followed appropriate infection control practices in a variety of areas affecting 2 of 20 sample residents (#21, #23) and 3 non-sample residents (#17, #20, #22). In addition, the facility failed to maintain current infection control data for three residents (#27, #56, #67) in order to ensure an active infection control program. The findings were: 1. Observations on 11/16/10 from 6:10 AM to	F 441	(b)Preventing spread of Infection (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 professional practice. (c)Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Corrective Plan: Residents #'s 20, 21, 22, 17 are receiving their medications after nurses are performing proper hand hygiene. Residents #'s 20 and 21 are receiving proper blood glucose testing by nurses using proper cleaning of glucometer after each use. Identification of Others: Residents receiving medication and residents receiving blood glucose testing. Systemic Changes: SDC/designee will re-educate nurses on but no limited to proper hand hygiene with medication administration and the importance of cleaning the glucometer after each use. [Need to add on or before 12/31/10) SDC/designee will do random weekly audits of medication passes for proper hand hygiene and cleaning of glucometer after each use.	

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F 441	Continued From page 22 6:25 AM showed RN #5 administered oral medications to four residents (#20, #21, #22, #17), and used a glucometer to perform glucose tests on two residents (#20, #21). The observation also revealed the RN did not perform hand hygiene before or after administering medications to each of the four residents; nor did she clean the glucometer between resident use. During an interview on 11/16/10 at 6:42 AM the RN stated she did not clean the glucometer because it was routinely cleaned once during each twelve hour shift. She further stated she did not realize she had not performed hand hygiene between resident contacts. On 11/16/10 at 9:45 AM the DON stated the nurses were expected to clean the glucometer between resident use and all staff had received education and training regarding hand hygiene before and after resident contact. 2. Observation on 11/17/10 at 3:07 PM showed RN #1 and #2 provided a dressing change for the wounds on the lower extremities of resident #23. The resident sat in a reclined lounge chair while the dressings were changed. At 3:26 PM when RN #1 took off the old bandage from the resident's left calf wound, RN #2 was finishing dressing a wound on the other foot. The left calf wound now exposed, rested directly on the upholstered foot rest. When RN #2 started treatment of the left calf wound, she noted it was draining pinkish red fluid when dabbed with a gauze pad. Interview with the two nurses at the end of the treatment revealed they should have put down a clean towel or pad to prevent the wound from coming into direct contact with the chair. 3. Review of the facility's infection control	F 441	Monitoring: 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 DON/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. Corrective Date: 12/31/10 Corrective Action: Drainage pads are being used during all wound care. Identification of Others: All residents receiving wound care Systemic Changes: Nurses educated by DON/designee on use of drainage pad with all wound care. Done on or before 12/31/10 Weekly Audit of wound care for use of drainage pad by DON/designee. Monitoring: 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 DON/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. Corrective Date: 12/31/10	

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F 441	Continued From page 23 program revealed the infection control (IC) nurse did not consistently document infectious organisms identified by laboratory reports, there was incomplete documentation regarding resolutions, and current data was not collected in a timely manner. Further review of the program revealed the following information regarding residents with infections had not been included in the infection control log: a. Medical record review for resident #27 showed a urine culture was collected on 11/12/10 and the physician ordered Bactrim (an antibiotic) for treatment of the resident's urinary tract infection on 11/15/10. b. Medical record review for resident #57 showed the resident was admitted to the facility on 10/21/10 with physician's orders to continue the Flagyl (antibiotic) for treatment of a gastrointestinal infection called C. difficile. c. Medical record review for resident #55 showed the resident was admitted to the facility on 10/7/10 with a physician's order to continue the intravenous antibiotic for treatment of endocarditis caused by a methicillin sensitive staphylococcus aureus infection. Interview with the IC nurse and DON on 11/17/10 at 3:10 revealed some of the inconsistencies and incomplete areas of the infection control program was due to having three different IC nurses during the past year. The DON also stated that in addition to failing to add residents #27, #57 and #55 to the infection control logs, staff had also forgotten to do follow up cultures for residents #55 and #57 after the antibiotic therapy was completed.	F 441	Corrective Action: Infection control logs are current and maintained by SDC/designee. Resident # 27 was added to infection control log. Resident # 57 was added to infection control log and follow up culture was obtained on 11/17/10 results negative for C-diff. Resident # 55 was added to infection control log. Identification of Others: Audit of admission and telephone orders for all residents receiving antibiotic from 11/1/10 will be completed by DON/designee. All residents identified will be added to infection control log. Systemic Changes: Review of 24 hour report and all new orders by IDT in morning meetings on Monday-thru Friday SDC/designee will update infection control log on a daily basis (Monday-Friday) during morning IDT meeting. Monitoring: 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 DON/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. Corrective Date: 12/31/10	12/31/10
F 467 S6=E	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC	F 467		

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F 467	Continued From page 24 The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide adequate ventilation in bathrooms for six of six hallways. The findings were: From observation upon entrance on 11/15/10 at 3:15 PM through exit on 11/18/10 at 12:30 PM, the facility had a noticeable odor of stale urine in each hallway. On 11/16/10 from 9 AM through 9:15 AM, bathroom ceiling vents were checked for ventilation adequacy (using a piece of tissue) in resident rooms 203, 205, 302, 308, 404, 407, and 410. In each case, the tissue failed to cling to the vent, and there was no noticeable air movement. On 11/18/10 from 7:25 AM through 7:45 AM, bathroom ceiling vents were checked for ventilation adequacy in resident rooms 103, 104, 503, 505, 506, 509, 610, and 611. With the exception of the vents in rooms 503 and 611, the vents failed to pull/move any air. During an interview with the maintenance director on 11/17/10 at 7 AM, he said he had been in the maintenance director position for three weeks and did not know if the maintenance schedule included a check of the ventilation system. During an interview on 11/18/10 at 8:15 AM, he was shown the results of the ceiling vent checks performed during the survey, and then shown vent check demonstrations in several rooms. At that time he stated the ceiling vents in each resident room needed to be checked individually.	F 467	F 467 It is the practice of the facility to have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. Corrective Actions: Affected bathroom vents were placed in proper operating condition Identification of others: All bathroom vents were inspected for proper working condition. Vendor will properly disinf all defective bathroom vents. Systemic Changes: Maintenance Director/designee will check all bathroom vents weekly Monday thru Friday to ensure proper working condition. Monitoring: Data obtained by way of audits will be reviewed and analyzed for patterns and trends and reported monthly to facility QA&A committee by Maintenance 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 monthly for 3 months. Corrective Date: 12/31/10	12/31/10

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F 467	Continued From page 25 He said ceiling ventilation failure would cause odors to permeate throughout the facility.	F 467		