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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535021	A. BUILDING _____ B. WING _____	12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYOMING RETIREMENT CENTER	690 US HWY 20 SOUTH BASIN, WY 82410

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F 000	INITIAL COMMENTS The following common abbreviations are used throughout this document: ADLs- Activities of Daily Living CAA- Care Area Assessment CNA- Certified Nurse Aide DON- Director of Nursing MDS- Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000	This Plan of Correction Constitutes our Allegations of Compliance.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. 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	F 278	Plan of Correction for those residents found to be affected: Resident #9 and resident #39 care plans were reviewed to make sure they accurately reflected each residents' status. Resident #9's toileting program was reviewed and determined to be appropriate for the resident. The toileting program shows that resident is to be toileted before and after meals, at bedtime, between 2300-2400, between 0300-0400 and as requested by resident. Nursing staff (including CNAs, RNs and LPNs) will be trained on resident toileting programs during in-services on January 14 and 15, 2014. Resident #39 was documented as being on a toileting program despite being a "check and change" only at this time due to condition. Resident's care plan, relevant MDS section, and toileting program were changed to reflect that a "check and change" was not a toileting program on December 5, 2013. MDS coordinator was educated on the fact that "check and change" was not a toileting program by a state surveyor on 12/5/13. During MDS Care Plan Meetings an interdisciplinary team including the MDS Nurse will address the "check and change" program and/or toileting program of each resident. The MDS Coordinator will address any changes in these	

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

Administrator | 1/10/2014

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

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F 278	Continued From page 1 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to accurately encode the MDS assessments for 2 of 13 sample residents (#9, #39). The findings were: According to the Long-Term Care Facility Resident Assessment Instrument User's Manual, MDS 3.0, Centers for Medicare & Medicaid Services, April 2012, "...A toileting program does not refer to simply tracking continence status, changing pads or wet garments, and random assistance with toileting or hygiene." The following concerns were identified related to the coding of toileting programs on the MDS: 1. Review of the medical record for resident #9 showed the resident was admitted to the facility on 6/30/11 with diagnoses including non-Alzheimer's dementia. Review of the annual MDS assessment dated 9/27/13 revealed the resident had disorganized thinking, verbal behaviors, hallucinations, required extensive assistance with toileting and had frequent urinary incontinence. The MDS identified the resident had been placed on a toileting program. Review of the CAA dated 9/21/13 identified the resident as having urinary incontinence. Review of the care plan updated 10/2/13 revealed the resident as frequently incontinent and interventions included staff assisting the resident with toileting and providing incontinence care. Observation on	F 278	Continued from page 1 programs with the charge nurse by submitting the care plan documentation into the residents' care plan books. CNA staff were educated at in-service on December 10 and 11, 2013 that if any resident's toileting program and/or care plan reflected a "check and change" to notify a supervisor so changes could be made if needed. Corrective Action for other residents having a potential to be affected: Toileting programs will be monitored by an established "Incontinence monitoring team" composed of day and night CNAs. The MDS Coordinator will work with the incontinence monitoring team to make sure the care plan accurately reflects each residents status. During the care planning meeting, the interdisciplinary team will review the bowel and bladder and/or check and change program to make sure that the MDS care plan accurately reflects the resident status. Incontinence monitoring team will report findings to Nurse Manager or designee monthly. Nursing Administration Team will develop and educate staff on a new Bowel and Bladder documentation flow sheet to ensure accurate following of toileting program. Measures taken to make sure this practice does not happen again:	

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F 278	Continued From page 2 12/4/13 from 9 AM to 11:15 AM showed the resident was confused, and staff were not observed taking the resident for scheduled toileting. Interview with CNA #1 on 12/4/13 at 9:50 AM revealed the resident was confused, was always incontinent, did not ask staff for assistance with toileting, and was not routinely taken to the bathroom for toileting. At 11:15 AM the resident was taken to his/her room and was observed to be incontinent of urine. 2. Review of the medical record for resident #39 revealed the resident was admitted to the facility on 12/28/12 with diagnoses including bilateral femoral fractures and non-Alzheimer's dementia. Review of the quarterly MDS assessment dated 9/13/13 showed the resident was cognitively impaired, required total assistance from staff for ADLs and was always incontinent of bowel and bladder. The MDS identified the resident as being on a toileting program. Review of the care plan updated on 9/19/13 identified the resident as having an alteration in bowel and bladder related to being confined to the reclining chair or bed. The care plan further listed the resident as always incontinent of bowel and bladder and was "check and change only." Review of a nursing note dated 12/2/13 for "an observation period," the resident was always incontinent and was check and change only due to non-weight bearing status. 3. Interview with the MDS coordinator on 12/5/13 at 10:10 AM revealed the facility had considered check and programs to be toileting plans.	F 278	Continued from page 2 The toileting programs will be developed and monitored by our incontinence monitoring team and the MDS Coordinator who will track those residents currently on Bowel and Bladder programs, as well as product usage by each resident. Changes in condition or residents needing check and change programs rather than Bowel and Bladder will be monitored by the monitoring team who will communicate with our nursing staff. The team will monitor documentation of completed assignments and will report their findings to the Nurse Manager or designee. Monitoring Performance: The incontinence monitoring team will be responsible for monitoring each resident's progress with their Bowel and Bladder program, including staff follow through on assignments and to make sure any program modifications are reflected in the residents' MDS care plan. The team will report monthly to the Nurse Manager, or designee success with each resident's program. The Nurse Manager or designee will report monthly to the Quality Assurance Committee for three (3) months and quarterly thereafter as compliance is demonstrated. Reporting will be complete as determined by the QA Committee. Completion Date: 01/26/2014	01/26/2014
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of	F 312	Plan of correction for those residents found to be affected:	

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F 312	Continued From page 3 daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident, family and staff interviews, the facility failed to provide grooming and personal hygiene assistance for 2 of 13 sample residents (#20, #39) and 2 non-sample residents (#44, #71) who required extensive or total staff assistance. The findings were: 1. Review of the medical record showed resident #20 had a diagnosis of Alzheimer's dementia. According to the 10/26/13 quarterly MDS assessment, the resident required extensive staff assistance for personal hygiene. Observation on 12/3/13 at 8:35 AM and again on 12/5/13 at 8 AM revealed the female resident had numerous chin hairs which were easily visible. An interview with CNA #2 on 12/5/13 at 8 AM revealed chin hairs should be shaved when the resident received a bath. The CNA stated the resident last had a bath on Monday (12/2/13), and confirmed the resident did have noticeable chin hairs. During an interview on 12/4/13 at 7:20 PM, a family member stated s/he had concerns with the grooming and hygiene of the resident. 2. Review of the medical record for resident #71 showed the resident was readmitted to the facility on 5/10/13 with diagnoses including cognitive/perceptual impairment. Review of the annual MDS assessment dated 9/20/13 showed the resident was dependent on staff for bathing	F 312	Continued from page 3 Resident #20's facial hair was shaved at next scheduled bath which was documented on December 7, 2013. Nail care for Resident #71 was documented as being completed on December 10, 2013. Nail care for Resident #44 was documented as being completed on December 8, 2013. Nail care for Resident #39 was documented as being completed on December 7, 2013 during their documented bath. Corrective action for other residents having a potential to be affected: All CNA staff were re-educated on nail care and proper care of nails for those residents who are diabetic at in-services on December 10 and 11, 2013. Nursing staff were inserviced on CNA responsibilities for fingernail care and nursing responsibilities for toenail care for our diabetic residents. During weekly facility rounds, the Director of Nursing, the Administrator, the Wound Care Specialist, and Education Director will visually observe residents' nail care to validate if documented nail care services were given by our nursing staff. If those observations result in unsatisfactory conditions, the nursing staff will be notified of unsatisfactory nail care and additional training will be provided. This will be documented in the facility log round book, and the facility round team will follow up the following week to determine compliance. All CNA staff were be given a copy of a power point presentation on bathing and nail care the	

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F 312	Continued From page 4 and required limited assistance with personal hygiene. Review of the 5/10/13 care plan showed the resident had a functional deficit for performing ADLs and staff provided needed assistance. The following concerns were identified: a. Observation on 12/3/13 at 10:05 AM, and on 12/5/13 at 8:10 AM showed the resident had long fingernails that were not clean. A dark colored substance was noticed under the long fingernails. b. Interview with CNAs #3 and #4 on 12/5/13 at 8:10 AM revealed nail care was performed on bath days and should be done as needed between baths. CNA #4 stated the nail clippers were sometimes missing from the shower rooms so nails did not always get trimmed. 3. Review of the medical record for resident #44 showed the resident was admitted to the facility on 7/20/09 with diagnoses including multiple sclerosis and traumatic brain injury. Review of the MDS quarterly assessment dated 10/10/13 revealed the resident had impaired decision making and required extensive assistance from staff to perform ADLs including hygiene and bathing. Review of the care plan updated 10/2/13 showed the resident had an alteration in ADLs related to end stage multiple sclerosis and mental impairments. Interventions included staff performing nail care as needed. The following concerns were identified: a. Observation on 12/3/13 at 9:55 AM revealed the resident had long, jagged fingernails with thick, brown matter encrusted in the nail beds on both hands. Observation on 12/5/13 at 8:55 AM revealed the resident's fingernails continued to be long and jagged and the nail beds continued to have thick, brown matter under the nail beds. Interview with the resident at the time	F 312	Continued from page 4 week of January 6, 2014. CNAs will be instructed that if bathing or nail care supplies are not available in the bath house to look in clean utility room, or contact commissary to get the needed items at in-services scheduled for January 14 and 15, 2014. An established bath monitoring team consisting of the two bath CNAs on the North unit and two floor CNAs on the South unit, will monitor documented completion of nail care and shaving of all residents on a monthly basis and report to the Nurse Manager or designee. Measures taken to make sure this practice does not happen again: The bath monitor team will be responsible for monitoring completion of baths, nail care, and shaving of all residents weekly. The team will report findings of their weekly audits to the Nurse Manager, or designee to determine compliance. The Nurse Manager, Education Specialist, Wound/ Infection Prevention Nurse, Social Worker, Facility Administrator, and floor and bath CNAs will conduct weekly rounds to observe and validate documentation and physical appearance of our residents. Monitoring Performance: The Nurse Manager or designee will report findings to the Quality Assurance Committee monthly for three (3) months and quarterly thereafter as compliance is demonstrated. Completion of monitoring will be determined by the QA Committee. Completion Date: 01/26/2014	01/26/2014

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F 312	Continued From page 5 of the 12/5/13 observation revealed s/he was unable to perform nail care independently and stated "I don't have enough strength in my hands." Interview further revealed it had been "about a month the last time my fingernails were cleaned and I don't remember the last time they were trimmed." 4. Medical record review showed resident #39 was admitted to the facility on 12/28/12 with diagnoses including non-Alzheimer's dementia. Review of the quarterly MDS assessment dated 9/13/13 revealed the resident was cognitively impaired and was totally dependent on staff for ADLs including hygiene and bathing. The following concerns were identified: a. Observation on 12/3/13 at 8:30 AM revealed the resident had long, jagged fingernails with brown matter under the nail beds. Subsequent periodic observations on 12/4/13 and 12/5/13 revealed the resident continued to have long, jagged fingernails with brown matter under the nail beds. b. Interview with CNA #1 on 12/5/13 at 8:50 AM verified the fingernails had not been trimmed or cleaned during the resident's bath the previous day related to not having enough staff. c. Interview with the DON on 12/5/13 at 10:15 AM revealed she expected staff to trim and clean resident's fingernails as needed and/or inform a nurse if a resident refused.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the	F 314	Plan of correction for those residents found to be affected:	

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F 314	Continued From page 6 individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff and resident interview, the facility failed to ensure interventions were implemented to promote healing and to prevent worsening of pressure ulcers for 2 of 3 sample residents (#8, #39) identified as having pressure ulcers. The findings were: 1. Review of the medical record for resident #39 showed the resident was admitted to the facility on 12/28/12 with diagnoses including bilateral femoral fractures and non-Alzheimer's dementia. Review of the quarterly MDS assessment dated 9/13/13 showed the resident was cognitively impaired, was dependent on staff for ADLs and had pressure ulcers. The CAA dated 1/7/13 also identified the resident as having pressure ulcers. Review of the care plan updated 9/19/13 showed the resident was at risk for impaired skin integrity and had a history of pressure ulcers. Interventions included repositioning the resident every hour with wedge cushions as needed. Further review of the medical record showed the resident had been referred to a surgeon for management of his/her pressure ulcers. The following concerns were identified: a. Observation of a dressing change on 12/4/13 at 2:30 PM with RN #1 revealed the resident had pressure ulcers on the outer lower left and right legs above the ankles.	F 314	Continued from page 6 The facility will ensure that a resident with a pressure ulcer receives the necessary treatment and services to promote healing and prevent new ulcers from developing. This will be accomplished by: a) Resident #39 was seen by a general surgeon for multiple issues, including the bilateral ankle pressure ulcers on December 17, 2013 at which time new orders were received for Physical Therapy to consult on the wounds and to apply dressings to consist of an Allevyn Thin, Unna Boot, and coban. Dressing changes currently are being done twice weekly; one by Physical Therapy and one by the Wound/Infection Prevention Nurse. Floor nursing staff will change dressings as needed or when the Wound/Infection Prevention Nurse is unavailable. Resident #39 was seen by his primary care physician on December 23, 2013 at which time the primary care physician did visualize the wounds as witnessed by the Nurse Manager and Administrator in Training. b) Resident #8's care plan was verified to state that the resident would be turned every 1 to 1.5 hours when in bed and if the resident refuses the CNA should inform the charge nurse. The Nurse Manager and/or Wound/Infection Prevention Nurse will supply the CNAs with a Turning Schedule Log for Resident #8 and any other residents who are bed ridden. CNAs will be educated on the use of this form at inservices scheduled for January 14 and 15, 2014. The Turning Schedule Log will be submitted to the Nurse Manager, or designee at the end of each day. c) The facility has ordered a positioning alternating mattress for Resident #39 and is currently assessing Resident #8's need. d) The facility dietician is monitoring the nutritional status for residents #39 and #8.	

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F 314	Continued From page 7 Measurements taken by RN #1 showed the pressure ulcer on the left leg measured approximately 6 cm (centimeters) by 2.5 cm. The pressure ulcer was dark red and had 2 open areas. The right lower leg wound measurements were reported by the RN as 5.3 cm by 3.6 cm with 2 open areas. In addition, the right lower leg had a dime sized area that was black and leathery which RN #1 verified was eschar (dead tissue). There were no visible wounds observed on the resident's heels. Review of the nursing notes dated 10/23/13 through 12/2/13 showed the resident had a "dark or brown scabbed area" on the right leg wound. b. Review of the medical record revealed a surgical consultation had been done and the physician's progress note dated 5/21/13 showed the resident underwent a blunt debridement (surgical removal of dead tissue) of pressure ulcers on the right and left legs. The note further showed the left leg ulcer was healing and measured 3 cm by 4 cm, had superficial depth, and was clean and healing. The resident had 2 ulcers on the right leg; an upper, which measured 2 cm by 1 cm, and the lower was deeper and measured 2 cm by 1.5 cm and was healing. The medical record further showed a surgical consultation dated 6/19/13 where the MD assessed the pressure ulcers on the right and left lower legs. There was no physician progress note in the resident's medical record for the visit on 6/19/13 until the DON obtained a copy of the progress note on 12/4/13 at 4:10 PM. According to the physician's progress note, the plan was for the resident to have a follow-up appointment for his/her pressure ulcers in 1 month. An interview with the DON at the time the progress note was received verified the resident had not been scheduled for a follow-up appointment, and had	F 314	Continued from page 7 Corrective action for other residents having a potential to be affected: For residents who have a potential to be affected by pressure area breakdown, the facility will complete the following: a) Make sure the attending physician evaluates the pressure areas visually at least every 60 days or as needed. Nurse Manager, or designee will round with the physician to make sure this is completed. b) Progress notes will be obtained on a timely basis and will be placed in the residents medical chart. c) Physicians who do not visit residents as required or as residents experience a change of condition will be given written warnings and/or lose their attending physician privileges at the WRC. d) A turning schedule will be followed by nursing staff for any resident who spends the majority of their time in bed. e) The facility will utilize pressure reducing mattresses wherever possible to help in the prevention and healing of pressure areas. f) Nursing will assess resident skin condition quarterly and as needed to ensure proper pressure reducing mattresses or positioning techniques are being utilized. g) The therapy department and the restorative CNAs will monitor residents in wheelchairs to ensure proper positioning and comfort. Recommendations for wheelchair cushions will be given to the nurse manager if supplies need to be ordered. h) The facility dietician will conduct quarterly nutritional assessments for all residents and	

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F 314	Continued From page 8 not seen the surgeon regarding the pressure ulcers since 6/19/13 (168 days). c. Review of physician progress notes showed the resident had been evaluated by his/her primary care physician on 8/20/13 and 10/22/13. However, there lacked evidence the pressure ulcers on the bilateral lower legs above the ankles were examined by the physician. 2. Review of the medical record for resident #8 showed the resident was admitted to the facility on 12/10/12 with diagnoses including multiple sclerosis. Review of the significant change MDS assessment dated 9/20/13 showed the resident was totally dependent on staff for ADLs, had impaired range of motion, and pressure ulcers. Review of the care plan updated on 10/24/13 identified the resident as having an alteration in skin integrity related to pressure ulcers and decreased independent mobility secondary to multiple sclerosis. Interventions included staff repositioning the resident off of his/her back every 1 to 1.5 hours when the resident was in bed, and if the resident refused the CNA should inform the charge nurse. The following concerns were identified: a. Observation on 12/3/13 at 8:40 AM through 11:30 AM revealed the resident was lying in bed positioned on his/her back. No staff were observed repositioning the resident. Interview with the resident at 11:30 AM verified staff had not repositioned the resident since s/he had "sat up for breakfast this morning around 7 o'clock." The resident also verified s/he was unable to change positions without staff assistance. The resident revealed staff did not reposition him/her every hour, "maybe a couple times a day." b. Observation of a dressing change on 12/3/13 at 2 PM with RN #3 showed the resident	F 314	Continued from page 8 monitor those residents with known pressure areas monthly to ensure adequate nutritional status to promote would healing. Measures taken to make sure this practice does not happen again: a) Nurse Manager or designee and Wound/ Infection Prevention Nurse will conduct rounds weekly to make sure documented turning has occurred and/or pressure reducing mattresses are working. b) The Nurse Manager and/or the Wound/ Infection Prevention Nurse will make sure the physicians have visited residents on a timely basis and have documented on any pressure areas, including any new orders. Physicians who do not round as required will be given written warnings and/or lose attending physician privileges at this facility. c) The charge nurse and nursing administration team will conduct spot checks to ensure residents with a turning schedule are positioned as documented by comparing the documentation with direct observation. d) Staff will be educated immediately if position of resident does not match documentation. If noted to be a continuing wide-spread issue, staff will be reeducated on repositioning and disciplined as needed. Monitoring Performance The Nurse Manager and/or Wound/Infection Prevention Nurse will monitor the Turning Schedule Logs weekly to ensure compliance. Monitoring results of the turning logs, pressure reducing measures and physician visit/ documentation compliance will be reported to the Quality Assurance Committee monthly for three (3) months	

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F 314	Continued From page 9 had a quarter sized open area on the right upper buttock. The wound bed was pink and moist and identified by the RN as a "stage 2." The skin surrounding the wound was thin and fragile. c. Interview with the DON on 12/5/13 at 10:15 AM revealed she expected staff to follow the care plan to turn and reposition every hour and/or notify the charge nurse if the resident refused.	F 314	Continued from page 9 (3) months and as determined by the committee thereafter. The facility Medical Director will monitor compliance with physician visits and documentation as part of his responsibilities with Quality Improvement. Any physicians who are not compliant will be contacted by him. Completion Date: 1/26/2014	01/26/2014
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, medical record review, and review of incident information and manufacturer's instructions, the facility failed to ensure safety devices were applied appropriately for 3 of 14 residents (#9, #12, #19) who used the wander guard system. In addition, the facility failed to ensure one of two units (the south unit) was adequately supervised to prevent accidents. The findings were: 1. Observation on 12/2/13 at 4:55 PM showed the doors to the secure dementia wing of the south unit were open. Interview with RN #2 on 12/2/13 at 5 PM revealed the doors remained open when there was a shortage of staff. The nurse further	F 323	Plan of Correction for those residents found to be affected: The facility will ensure the resident environment remains as free of accident hazards as possible. Each resident receives adequate supervision and assistive devices to prevent accidents. This will be accomplished by: a) The wander guard signaling devices for Resident #12, #19 and #9 were removed from their respective wheelchair or walker(s) and were placed on each of their left ankles. At this time, the wander guard signaling device has been completely removed from Resident #12 as her condition has declined where family and staff do not feel she is a wander risk. b) Nursing staff were educated on warnings included in the manufacturer's instructions for wander guard signaling devices which states "Do not place the signaling device on or next to metal, such as wheelchair frames...metal could interfere with the signal sent to the door modules" at an in-service on December 10 and 11, 2013.	

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	535021	A. BUILDING _____ B. WING _____	12/05/2013

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F 323	Continued From page 10 stated there were several residents with psychiatric diagnoses on the south unit, and they "do not mix well" with the residents who have dementia. The following concerns were identified: a. Review of the facility incident log showed on 11/8/13 at 6:30 PM and 11/9/13 at 7:30 PM resident to resident altercations took place on the south unit. Resident #68 who lived on the dementia unit had wandered out of the sometimes secured unit into other resident rooms. These two incidents were physical in nature; however, did not result in injuries. Review of the incident investigations showed the doors to the dementia unit had been open because there were only two CNAs available, and recommended interventions included adjusting staff to have 3 CNAs working the night shift. b. Interview with resident #49 who lived on the south unit revealed s/he was afraid someone may get hurt and felt that the facility needed to provide enough CNAs to ensure the unit could be secured to keep the residents with dementia from wandering. This resident was aware of the incidents that had occurred and further stated s/he had reported his/her concerns to staff. c. Interview with the DON on 12/4/13 at 3:20 PM verified there were 6 CNA vacancies and due to this shortage, they were unable to always staff 3 CNAs on the south unit. The DON stated the planned staffing pattern was to have 1 CNA dedicated to the locked dementia unit and 2 others for the main floor of the south unit. 2. Periodic observations 12/2/13 through 12/5/13 revealed residents #12, #19 and #9 had wander guard signaling devices (electronic devices used to decrease and/or prevent unsafe episodic wandering) attached to the metal frames on their wheelchairs. Review of facility documentation also verified these residents had a wander guard	F 323	Continued from page 10 c) Currently the facility has two part-time positions open. Five positions currently are unable to work because of leave of absences or other reasons. The facility is actively recruiting for the two vacant part-time CNA positions and is working on getting the other five positions back to work as we can. d) Nursing staff have been instructed that the dementia doors are to remain closed. This will be reiterated at the in-service scheduled for January 14 and 15, 2014. Corrective action for other residents who have a potential to be affected: The following will be completed for other residents who have a potential to be affected: a) The Nurse Manager or designee will continue to monitor staffing levels and continue to fill open positions. Administration is working on getting employees who are on leave of absences, or who need back ground checks or CNA training completed, back to work. b) Staff will be retrained on keeping the South Dementia unit doors closed to prevent negative interactions between the residents on the dementia and psych units. c) The Nurse Manager or designee will monitor placement of wander guard signaling devices to make sure they are placed according to manufacturers recommendations. Measures taken to make sure this practice does not happen again: a) The facility will make sure the South Dementia unit doors remain closed. This will be accomplished through staffing the unit, training employees to keep the doors closed,	

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F 323	Continued From page 11 signaling device placed on their wheelchair. Review of the "First Q Wander Guard Departure Alert System Users Instructions" showed the signaling devices "...are designed to be worn on a wrist but can be placed on an ankle..." In addition, a black bold print warning box in the instruction manual showed, "Do not place the signaling device on or next to metal, such as wheelchair frames...metal could interfere with the signal sent to the door modules." The following concerns were identified: a. Observation of residents #12 and #9 on 12/2/13 at 4:35 PM and observation of resident #19 on 12/3/13 at 8:55 AM and subsequent periodic observations through 12/5/13 revealed the residents had wander guard signaling devices attached to the metal frames on their wheelchairs. b. Interview with the DON on 12/4/13 at 5 PM verified residents #9, #12, and #19 were identified as having wandering behaviors and had their wander guard signaling devices placed on the metal frames of their wheelchairs. The interview further revealed she was unaware of the warnings included in the manufacturer's instructions for the wander guard signaling devices.	F 323	Continued from page 11 administrative compliance rounds and through disciplinary actions as needed. b) Will continue to monitor staffing levels, replace open positions as needed and work in keeping scheduled employees working their shifts. c) The Nurse Manager, or designee will monitor placement of wander guard signaling devices on each resident to make sure they are placed according to manufacturer's recommendations. d) A flow sheet will be implemented for staff to document that the dementia doors are closed. Flow sheets will be monitored by nursing administration weekly to ensure compliance. e) Nursing administration and the facility administrator will conduct spot checks either in person or via review of security tape to ensure the doors remain closed. Monitoring Performance The Nurse Manager, or designee will report to the QA Committee monthly, for three months, results of her audits concerning staffing, South Dementia unit door closures and signaling device placement. The Committee will recommend further training, staffing alternatives or other recommendations until desired compliance is attained. Completion Date: 01/26/2014	01/26/2014
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient	F 353	Plan of Correction for those residents found to be affected: While the Wyoming Retirement Center schedules nursing care hours above the required 2.25 hours for each skilled resident during a 24 hour time period, the facility has secured units which require additional staffing to maintain. It is possible for negative interactions to develop if either dementia unit doors remain open during times when residents are awake and could move into other nursing units.	

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F 353	Continued From page 12 numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and review of incident information, the facility failed to provide sufficient numbers of nursing staff for one of two nursing units (the south unit) related to resident supervision. The census on the south unit was 28. The findings were: Observation on 12/2/13 at 4:55 PM showed the doors to the secure dementia wing of the south unit were open. Interview with RN #2 on 12/2/13 at 5 PM revealed the doors remained open when there was a shortage of staff. The nurse further stated there were several residents with psychiatric diagnoses on the south unit, and they "do not mix well" with the residents who have dementia. Six residents lived on the secure dementia unit, there were 22 residents who lived on the main south unit. The unit was designed to be secured to separate the dementia residents from the larger more populated area. The following concerns were identified:	F 353	Continued from page 12 Corrective action for any resident living in the facility: Corrective action to address issues stated in this deficiency include: a) Closing the Dementia unit doors so dementia residents do not wander into other resident areas. b) Staffing the dementia unit(s) so the doors remain closed. c) Training staff and monitoring the doors to make sure they remain closed. Nurse Manager or designee will monitor staffing daily to ensure adequate staffing and will continue to fill open positions and work to get employees who are out on leave of absences back to work. The facility will provide training to our employees on the need to keep our dementia unit door(s) closed and will staff the units so the doors will remain closed. Measures taken to make sure this practice does not happen again. An in-service has been scheduled on January 14 and 15, 2014 to train staff to keep the dementia door(s) closed and on possible negative behaviors that may result if dementia residents are allowed to enter other resident areas. The facility currently has 2 part-time CNA positions that are open. While we have filled some positions, we currently have 5 employees who cannot work at this time who still hold current positions. The facility will therefore continue to fill open positions and will work to get these other five employees back to work. Nursing staff have been instructed the	

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F 353	Continued From page 13 a. Review of the facility incident log showed on 11/8/13 at 6:30 PM and 11/9/13 at 7:30 PM resident to resident altercations took place on the south unit. Resident #68 who lived on the dementia unit had wandered out of the sometimes secured unit into other resident rooms. These two incidents were physical in nature; however, did not result in injuries. Review of the incident investigations showed the doors to the dementia unit had been open because there were only two CNAs available, and recommended interventions included adjusting staff to have 3 CNAs working the night shift. b. Interview with resident #49 who lived on the south unit revealed s/he was afraid someone may get hurt and felt that the facility needed to provide enough CNAs to ensure the unit could be secured to keep the residents with dementia from wandering. This resident was aware of the incidents that had occurred and further stated s/he had reported his/her concerns to staff. c. Interview with the DON on 12/4/13 at 3:20 PM verified there were 6 CNA vacancies and due to this shortage, they were unable to always staff 3 CNAs on the south unit. The DON stated the planned staffing pattern was to have 1 CNA dedicated to the locked dementia unit and 2 others for the main floor of the south unit.	F 353	Continued from page 13 doors to the dementia unit are to remain closed and staffing adjusted to cover these areas. It is the expectation that if necessary, the charge nurse can assist on the floor. A flow sheet will be implemented for staff to document that the dementia doors are closed. Flow sheets will be monitored by nursing administration weekly to ensure compliance. Nursing administration and the facility administrator will conduct spot checks either in person or via review of security tape to ensure the doors will remain closed. Monitoring Performance: Results of nursing administration spot checks, flow sheet documentation, and staffing levels will be reported to the QA committee monthly for three months and thereafter as determined by the QA committee as compliance is demonstrated. Completion Date: 01/26/2014	01/26/2014
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	Plan of Correction for those residents found to be affected: While no specific residents were mentioned in this deficiency, any resident of the facility could be affected. It is the policy of the Wyoming Retirement Center to have a clean food and non-food contact surfaces, utensils, and equipment, which will be kept free from dust, dirt, food residue and other debris.	

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F 371	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a sanitary environment in 5 of 6 kitchen/food areas (north unit, south unit, north dementia unit, south dementia unit, and the activity/therapy department). The findings were: Interview with the dietary manager on 12/4/13 at 3:30 PM verified she was new to the position, and was not aware of the requirements for hair restraints. According to Food Code 2013, U.S. Public Health Service: 2-402.11 "(A) Except as provided in ¶(B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. (B) This section does not apply to food employees such as counter staff who only serve beverages and wrapped or packaged foods, hostesses, and wait staff if they present a minimal risk of contaminating exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles." 1. Observation of the microwave on the south dementia unit on 12/3/13 at 8:50 AM, and on 12/5/13 at 8:10 AM showed it was not clean. The interior of the microwave had dried spilled food and crumbs. Observation on 12/5/13 at 9:40 AM	F 371	Continued from page 14 a) On December 10 and 11, 2013, the Dietary Manager dispersed hairnets, rubber gloves and apron's to the CNA's serving food on the north and south nursing units and instructed the CNA's that it is mandatory to wear the aforementioned items when serving food. On December 10 and 11, 2013, the CNAs were trained on this requirement. b) The cleaning of the microwaves on the north and south dementia units are assigned to CNA staff to be cleaned daily. This practice will be documented on the chore list. On December 10 and 11 the CNA's were re-in serviced on this policy and the necessity for the microwaves to be cleaned daily. c) The facility will use covered bait in a contained, covered and tamper-resistant bait station. Staff will be instructed on 1/7/2014 to request maintenance staff members to distribute the traps via work orders so they are the only staff handling the traps in order to prevent staff from setting traps that are not approved. Measures taken to make sure this practice does not happen again: a) The Dietary Manager, Administrator, Nurse Manager and charge nurse will conduct spot checks to make sure CNAs are wearing hair nets, gloves and aprons while serving food. Spot checks will be completed on a weekly basis starting 1/8/2014. b) The Dietary Manager is performing spot checks on the cleanliness of the microwaves in the north and south units. The chore list will be monitored by the Nurse Manager or designee to ensure compliance with cleaning the microwaves. c) Staff will be re-inserviced on our policy concerning rodent traps. The Wyoming Retirement Center will update policies and procedures to reflect this policy. A work order will be completed and given to our maintenance staff	

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F 371	Continued From page 15 showed the microwave located on the women's dementia unit (north) was not clean. The interior was soiled with dried food. Interview with the dietary manger on 12/5/13 at 9:50 AM stated she was unsure who was responsible for the cleaning of the microwaves. She then stated it needed to be assigned and the microwaves needed to be cleaned daily. According to Food Code 2013, U.S. Public Health Service: 4-601.11 "(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch...(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." 2. Observation on 12/5/13 at 9:25 AM showed an uncovered baited snap-style mouse trap located on the floor between the counter and the refrigerator in the activity/therapy room. According to Food Code 2013, U.S. Public Health Service: 7-206.12: "Rodent bait shall be contained in a covered, tamper-resistant bait station." 3. Observation on 12/3/13 at 11:50 AM, and at 5 PM showed CNA #5 worked as a food service employee and dished up resident meals from the steam table located on the south unit. During these observations it was noted the CNA failed to wear a hair restraint. Interview with the CNA on 12/3/13 at 5 PM revealed she was unaware hair restraints were required. Observations of meal service on the north unit on 12/2/13 at 5:05 PM and on 12/3/13 at 11:55 AM revealed CNA #6 was working behind the steam table over uncovered food to dish food onto plates. The CNA was not wearing a hair restraint.	F 371	Continued from page 15 If rodent traps are needed to be set, or to coordinate with our contracted exterminator for services. Housekeeping staff will be in-serviced to look for traps that are not approved for this facility as they clean rooms and will report back to the Environmental Services Manager after removing the traps. Monitoring Performance The Dietary Manager or designee will conduct spot checks on the north and south units to make sure our microwave ovens are being cleaned according to schedule. The Dietary Manager will also observe the CNAs during meal times to make sure they are wearing hairnets, gloves, and aprons while serving in addition to the Administrator, Nurse Manager and Charge Nurse. The Environmental Services Manager will report the number of work orders for rodent bait traps, and results of inspections by her dietary staff to locate any traps that may be in the facility that are not appropriate. The Dietary Manager will be responsible to gather this information and report to the QA Committee for the next three months and at a frequency which will be determined by the committee as compliance is demonstrated. Completion Date: 01/26/2014	01/26/2014
F 385	483.40(a) RESIDENTS' CARE SUPERVISED BY	F 385	Plan of Correction for those residents found to be affected:	

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F 385 SS=D	Continued From page 16 A PHYSICIAN A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the physician monitored changes in the medical condition and provided consultation as needed for 1 of 13 sample residents (#39). The findings were: Review of the medical record showed resident #39 was admitted to the facility on 12/28/12 with diagnoses including bilateral femoral fractures and non-Alzheimer's dementia. Review of the quarterly MDS assessment dated 9/13/13 showed the resident was cognitively impaired, was dependent on staff for ADLs and had pressure ulcers. The CAA dated 1/7/13 identified the resident as having pressure ulcers. Review of the medical record showed the resident had been referred to a surgeon for the management of his/her pressure ulcers. The following concerns were identified: a. Review of the medical record revealed a surgical consultation had been done and the physician's progress note dated 5/21/13 showed the resident underwent a blunt debridement	F 385	Continued from page 16 The facility will ensure that medical care of each resident is supervised by a physician and another physician supervises the medical care of residents when their attending physician is unavailable. a) Resident #39 was seen by a general surgeon for multiple issues, including the bilateral ankle pressure ulcers on December 17, 2013 at which time new orders were received for Physical Therapy to consult on the wounds and to apply dressings to consist of an Allevyn Thin, Unna boot, and coban. Dressing changes are currently being completed twice weekly; one by a Physical Therapist and one by the Wound/Infection Prevention Nurse. Floor nursing staff change dressings as needed or when the Wound/Infection Prevention Nurse is unavailable. b) Resident #39 was seen by his primary care physician on December 23, 2013 at which time the primary care physician did visualize the wounds, as witnessed by the Nurse Manager and Administrator in Training. Corrective action for other residents having a potential to be affected: Any resident of the facility could be affected if their medical care is not supervised by a physician or another physician in the event their attending physician is unavailable. The facility will: a) Make sure the attending physician evaluates the wound/pressure area at least every 60 days or as needed. The Nurse Manager, or designee will round with the physician to make sure this is completed. b) Progress notes will be obtained timely and will be placed in the medical chart.	

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F 385	Continued From page 17 (surgical removal of dead tissue) of pressure ulcers on the right and left legs. The note further showed the left leg ulcer was healing and measured 3 cm (centimeters) by 4 cm, had superficial depth, and was clean and healing. The resident had 2 ulcers on the right leg; an upper, which measured 2 cm by 1 cm, and the lower was deeper and measured 2 cm by 1.5 cm and was healing. The medical record further showed a surgical consultation dated 6/19/13 where the MD assessed the pressure ulcers on the right and left lower legs. There was no physician progress note in the resident's medical record for the visit on 6/19/13, until the DON obtained a copy of the progress note, on 12/4/13 at 4:10 PM. According to the physician's progress note the plan was for the resident to have a follow-up appointment for his/her pressure ulcers in 1 month. An interview with the DON at the time the progress note was received verified the resident had not been scheduled for a follow-up appointment, and had not seen the surgeon regarding the pressure ulcers since 6/19/13 (188 days). The interview further revealed the resident's primary care physician (PCP) was often slow in responding regarding coordination of care and had to be called or faxed several times before responding. b. Review of physician progress notes showed the resident had been evaluated by his/her PCP on 8/20/13 and 10/22/13. However, there lacked evidence the pressure ulcers on the bilateral lower legs above the ankles were examined by the physician.	F 385	Continued from page 17 Measures taken to make sure this practice does not happen again: The Medical Records staff will monitor the physician round schedule to make sure the physician comes in within proper time frames and reviews residents. As part of this check, the Nurse Manager, or designee will access the residents medical issues to make sure the physician addresses them. Our medical records staff will track physician visits to make sure visit documentation is received on a timely basis. Notices will be sent out if physician documentation is not completed timely. Physicians who fail to come in to review residents or who fail to provide documentation of such a visit will receive a warning by our Medical Director who will monitor for compliance. Continued failure to visit residents timely and provide documentation will result in the physician's attending privileges being revoked at the facility. Monitoring Performance: Our medical records staff will monitor timeliness of visits and will report to the Nurse Manager or designee compliance with physician rounds and timely receipt of progress notes. The Nurse Manager, or designee will monitor if the physician has addressed medical issues during their visits and will report timeliness and appropriateness of visits and documentation to the QA Committee monthly to ensure compliance. The Medical Director, as part of the QA process, will review physician compliance as well. Completion Date: 01/26/2014	01/26/2014
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441	Plan of Correction for those residents found to be affected:	

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F 441	Continued From page 18 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (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 observation, staff and resident	F 441	Continued from page 18 Residents #42, #39 and #2 will be educated in regards to their right to ask staff if they have washed their hands, will wear gloves, and will dispose of trash appropriately. Residents will be educated during the January Resident Counsel meeting on January 8, 2014. Any residents who do not attend meetings will be educated individually. Nursing staff will be educated on appropriate hand washing, perineal care, and infection control practices (including disposal of waste material) at in-service scheduled for January 14 and 15, 2014. The Wound/Infection Prevention Nurse will conduct audits on perineal care, handwashing, and proper techniques monthly and will report her results to the QA Committee. Staff that do not follow proper procedures will given additional training and/or disciplinary actions. Corrective action for other residents having a potential to be affected: Corrective action for other residents having a potential to be affected is the same as for those found to be affected. Namely: a) Residents will be educated during the January Resident Counsel meeting in regards to their right to ask staff if they have washed their hands, will wear gloves, and will dispose of trash appropriately. b) Nursing staff will be educated on appropriate hand washing, perineal care, and infection control practices at an in-service scheduled for January 14 and 15, 2014.	

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	535021	A. BUILDING _____ B. WING _____	12/05/2013

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F 441	Continued From page 19 interview, and review of facility policy, the facility failed to ensure standard precautions were followed during incontinent/perineal care for 2 of 2 residents (#39, #2) observed for incontinent/perineal care. In addition, the facility failed to ensure single use peri-care wipes were properly disposed of during 1 random observation (#42). The findings were: 1. Observation on 12/2/13 at 5:05 PM revealed resident #42 was seated in a recliner in his/her room. There was an odor of urine in the area. The resident's bedside table was cluttered with an empty package of Prevail disposable wipes. There were numerous visibly soiled wipes partially covering the empty package and lying atop the table. The soiled wipes were spotted with yellow and light tan stains. Interview with the resident at the time of the observation revealed staff had assisted him/her with incontinent care and, "must have left them laying there." 2. Observation of incontinence care for resident #39 on 12/3/13 at 8:30 AM with CNA #6 and CNA #7 revealed the following: a. The resident was incontinent of urine and soft, brown stool. CNA #7 reached into a clean package of wipes with gloves that were visibly soiled with stool. b. CNA #7 removed her soiled gloves and, without washing her hands, proceeded to place a clean brief on the resident and place a clean incontinent pad under the resident. The CNA then removed the fitted sheet which was visibly soiled with stool with her bare hands. The CNA also placed the package of contaminated wipes on the resident's bedside table with her bare hands. c. CNA #7 continued to assist CNA #6 reposition the resident, apply a clean fitted sheet	F 441	Continued from page 19 c) The Wound/Infection Protection Nurse will conduct audits on perineal care, handwashing and proper techniques monthly and will provide additional training as needed to our staff. Staff that do not follow proper procedures will be given disciplinary actions. Measures taken to make sure this practice does not happen again: a) Train and monitor staff as they perform handwashing, perineal care and infection control practices to make they are following proper procedures. b) Staff members will be re-educated as issues arise during the audits. c) Staff members will be disciplined if they do not follow procedures after having been trained. Monitoring Performance: The Would/Infection Prevention Nurse will conduct monthly audits on handwashing, perineal care and infection control practices to ensure staff are trained and follow established practices. She will report her findings to the QA Committee monthly for 6 months and thereafter as determined by the QA Committee as compliance is demonstrated. Completion Date: 01/26/2014	01/26/2014

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F 441	Continued From page 20 and pillow case, and removed soiled linens and trash from the resident's room with her bare (unwashed) hands. 3. Observation of perineal care for resident #2 on 12/3/13 at 9:55 AM revealed CNA #7 used hand sanitizing gel to her clean hands (no gloves were applied). The CNA then assisted the resident to pull down his/her clothing and a disposable adult brief, and transfer to the toilet. After toileting, the CNA assisted the resident with perineal care/wiping with her bare hands. 4. Review of facility policy entitled, "Perineal Care" reviewed 11/15/10 instructed under "procedure 6. Put on gloves". 5. Interview with the DON on 12/4/13 at 9:20 AM revealed she expected staff to place used perineal wipes in the trash. She also expected staff to wear gloves when assisting residents with toileting and performing perineal and/or incontinent care. 6. According to, "The Long Term Care Guide for Infection Control" copyright 2008, "Gloves serve an important purpose in infection control...and are worn to provide a barrier against pathogens and prevent contamination...gloves should be worn in all situations where you may come in contact with blood or body fluids (providing incontinence care)...gloves should be changed when contaminated and between soiled and clean areas". In addition, current standards of practice from the Centers for Disease Control (CDC) dated May 2011, "Standard Precautions are the minimum prevention practices that apply to all patient care...2. use of personal protective equipment [gloves] should be worn when there is	F 441		

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F 441	Continued From page 21 contact with blood and/or body fluids...4. safe handling of soiled material, items soiled with blood and/or body fluids should be disposed of immediately after use in the appropriate container..."	F 441		
F 497 SS=F	483.75(e)(6) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interviews, the facility failed to complete annual performance reviews to ensure continued competencies for 20 of 20 CNAs who were employed for over one year. The findings were: Interview with the DON and the education specialist on 12/4/13 at 9:20 AM revealed the facility currently did not perform annual performance reviews to verify skill levels of the CNAs employed by the facility. No additional documentation was provided related to annual	F 497	Plan of Correction for those residents found to be affected: While no specific residents were mentioned in this deficiency, any resident has the potential to be affected. Corrective action for other residents having a potential to be affected: In order to ensure that a performance review of every nurse aide is completed every 12 months the facility will: a) Develop a CNA competency skills checklist by January 10, 2014 to include any skills CNAs at the facility are expected to be able to perform. b) CNA staff will be evaluated by the Nurse Manager, Education Specialist, or Wound/ Infection Prevention Nurse for skills competencies starting January 13, 2014 and annually in March thereafter. New CNAs will be evaluated upon employment and annually in March thereafter. c) Documentation of annual skills competencies will be kept by the Education Specialist with a copy also placed in employee's personnel file. Measures taken to make sure this practice does not happen again: Education on competencies will be provided in two parts: a) Six (6) hours of education will be provided through the Nurse Aide/VIP publication.	

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F 497	Continued From page 22 in-services or evaluations of CNAs. Interview with CNA #8 on 12/4/13 at 5:45 PM revealed s/he had worked at the facility for about 18 months. The interview further revealed, except for handwashing and abuse, skills involving assisting residents with ADLs were not reviewed annually.	F 497	Continued from page 22 These will be distributed monthly, completed independently and reviewed during nursing staff meetings the following month. b) Six (6) hours of face-to-face education/training will be provided on odd numbered months during CNA meetings. The education provided during these meetings will be based on areas of weakness established during CNA competency reviews. The January training will be on abuse, hand washing, perineal care, and infection control practices due to deficiencies in the survey and known areas of concern.	
F 498 SS=F	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure CNA skills were assessed to determine competency for 33 of 33 employed CNAs. The findings were: 1. Interview with the DON and the education specialist on 12/4/13 at 9:20 AM revealed the facility currently did not assess CNAs to determine competency skill levels. The current process was to team newly hired CNAs with another CNA for a couple of days. The DON revealed background checks were performed and certification listings were reviewed to determine current certifications. No additional documentation was provided regarding assessing the competency of CNAs employed by the facility. 2. Interview with CNA #8 on 12/4/13 at 5:45 PM revealed s/he had worked at the facility for about 18 months. The interview further revealed the	F 498	Monitoring Performance: The Education Specialist will keep a sign-in sheet for all face-to-face meetings, and will keep documentation of completion of Nurse Aide/VIP training completion for all CNAs. She will report areas of concern established during initial CNA competency reviews and compliance with training attendance and Nurse Aide/VIP publication completion monthly to the QA Committee for six (6) months and quarterly thereafter. Completion Date: 01/26/2014 Plan of Correction for those residents found to be affected: While no specific resident were mentioned in this deficiency, any resident has the potential to be affected. Corrective action for other residents having a potential to be affected: In order to ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the care plan the facility will:	01/26/2014

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F 498	Continued From page 23 CNA had never had staff verify his/her skills, including assisting the resident with ADLs such as bathing, transferring, and toileting. The CNA indicated newly hired CNAs worked with CNAs that had been employed for "a while," for a couple of days to learn "the routine." CNA #8 also revealed skills were not reviewed yearly, except they reviewed handwashing and abuse periodically. 3. The following concerns were identified related to CNA skills/techniques: a. Observation on 12/2/13 at 5:05 PM revealed resident #42 was seated in a recliner in his/her room. There was an odor of urine in the area. The resident's bedside table was cluttered with an empty package of Prevail disposable wipes. There were numerous visibly soiled wipes partially covering the empty package and lying atop the table. The soiled wipes were spotted with yellow and light tan stains. Interview with the resident at the time of the observation revealed staff had assisted him/her with incontinence care and "must have left them laying there." b. Observation of incontinence care for resident #39 on 12/3/13 at 8:30 AM with CNA #6 and CNA #7 revealed the following: The resident was incontinent of urine and soft, brown stool. CNA #7 reached into a clean package of wipes with gloves that were visibly soiled with stool. CNA #7 removed the soiled gloves and, without washing her hands, proceeded to place a clean brief on the resident and a clean incontinent pad under the resident. She then removed the soiled sheet with her bare hands. The CNA also placed the package of contaminated wipes on the resident's bedside table with her bare hands. CNA #7 continued to assist CNA #6 reposition the resident, apply a clean fitted sheet and pillow	F 498	Continued from page 23 a) Develop a CNA competency skills checklist by January 10, 2014 to include any skills that CNAs at the facility are expected to be able to perform. b) CNA staff will be evaluated by the Nurse Manager, Education Specialist, or Wound/ Infection Prevention Nurse for skills competencies starting January 13, 2014 and annually in March thereafter. New CNAs will be evaluated upon employment and annually in March thereafter. c) Documentation of annual skills competencies will be kept by the Education Specialist with a copy also placed in employee's personnel file. Measures taken to make sure this practice does not happen again: Following the completion of all CNA competency evaluations the Nursing Leadership Team, consisting of the Nurse Manager, Education Specialist, and Wound/Infection Prevention Nurse, will determine how staff will be educated on areas where competency was not achieved. a) If skill competencies are not achieved by a limited number of CNAs, those CNAs will be educated and trained individually and competency(s) re-evaluated. b) When skill competency is not achieved by a majority of the CNA staff education and training will be provided as a group during scheduled monthly CNA staff meetings and competency re-evaluated. c) New hire CNAs will work on the floor independently until they are proficient in all skills that CNAs in the facility are expected to be able to perform. Monitoring Performance: The Education Specialist will keep a copy of each CNA's initial and annual competency skills checklists and a copy will be placed in each CNA's personnel file. The Education Specialist will report	

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F 498	Continued From page 24 case and remove soiled linens and trash from the resident's room with her bare (unwashed) hands. c. Observation of perineal care for resident #2 on 12/3/13 at 9:55 AM revealed CNA #7 used hand sanitizing gel to her clean hands (no gloves were applied). The CNA then assisted the resident to pull down his/her clothing and a disposable adult brief, and transfer to the toilet. After toileting, the CNA assisted the resident with perineal care/wiping with her bare hands.	F 498	Continued from page 24 areas of concern established during the initial competency evaluations to the QA Committee with plan on how education and training will be provided. Nurse Manager, Education Specialist, and Wound/Infection Prevention Nurse will perform random audits of select skills monthly to ensure continued proficiency between annual reviews and report findings to the QA Committee monthly for three (3) months and quarterly thereafter as compliance is demonstrated. Date of Completion: 01/26/2014	01/26/2014