Approved ☺ Chgs on pages 8b, 20, 29 & 30 made. Received ☺ NHA 2/13/14 at 3:30 pm. All target completion dates chgd to 2/19/14 per request of NHA and Dan Stacks. Linda Brosnan 2/13/14

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

RECEIVED FEB 03 2014 WY Dept of Health Healthcare Licensing

PRINTED: 01/24/2014
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 01/09/2014

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 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 IP: Infection Preventionist LPN: Licensed Practical Nurse MDS: Minimum Data Set PPE: Personal Protection Equipment RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	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 correction is the facility's credible allegation of compliance.	
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, staff interview, and medical record review, the facility failed to ensure staff maintained the dignity of 4 of 17 sample residents (#6, #19, #41, #64). The findings were: 1. Review of the 12/18/13 quarterly MDS assessment showed resident #64 required limited assistance from staff with eating and dressing. Observation on 1/8/14 at 4:40 PM showed the resident was seated in a wheelchair in the television area. As the resident spoke to the	F 241	**F241** 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:** Resident #64 will be assessed for level of assistance needed with meals, including use of clothing protector and adaptive equipment by Director of Nursing or designee. Care plan and C.N.A. assignment sheet will be updated as necessary to reflect changes. Resident #19 will be assessed for level of assistance needed with meals, including use of clothing protector and adaptive equipment by Director of Nursing or designee. Care plan and C.N.A. assignment sheet will be updated as necessary to reflect changes.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Teresa J. Ralph, NHA	Administrator	2/3/14

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 241	Continued From page 1 surveyor at that time, the resident was noted to have dried food on his/her shirt, jacket, pants and shoes. An additional observation on 1/7/14 from 8:30 AM to 8:45 AM revealed the resident was sitting in the dining room attempting to eat breakfast without staff assistance. The resident was not wearing a clothing protector and food spillage was noted on the resident's shirt and pants. An observation at 1:15 PM, later that day, showed the resident was leaving the dining room after the noon meal wearing the same soiled clothing observed in the morning. Interview on 1/9/14 at 9:55 AM with CNA #4 revealed the resident refused to wear a clothing protector. The CNA also verified that it was inappropriate to leave the resident in soiled clothing. 2. Review of the 12/2/13 quarterly MDS assessment showed resident #19 required extensive assistance for eating and dressing. Observation on 1/8/14 at 10:10 AM revealed the resident was seated in the main living area of the secure unit. The resident was in a wheelchair and had pieces of fried egg and toast crumbs on his/her pants. The resident was observed at 8 AM that same day having breakfast. 3. Review of the 12/10/13 quarterly MDS showed resident #41 required extensive assistance with ADLs including dressing and hygiene. Review of the 12/12/13 plan of care revealed staff were directed to assist the resident with ADLs. Observation on 1/7/14 at 8:20 AM revealed CNA #5 wheeled the resident from the dining room to his/her room. At that time there was an area of spilled food and fruit juice on the front of the resident's shirt that extended from the neckline to	F 241	Resident #41 will be assessed for level of assistance needed with meals, including use of clothing protector and adaptive equipment by Director of Nursing or designee. Care plan and C.N.A. assignment sheet will be updated as necessary to reflect changes. Resident #6 was removed from contact isolation on 1/8/2014 by Staff Development Coordinator after confirmation of negative lab results. **Identification of Others:** A visual observation audit of residents at meal time will be completed by Rehab Manager or designee to identify any residents with dignity concerns related to dining. For those identified further review will be completed by interdisciplinary team and care plans and C.N.A. assignment sheets updated to reflect changes. The Staff Development Coordinator will review any residents on isolation precautions to determine if precautions are still necessary. Corrective actions will be taken as needed. **Systemic Changes:** The Staff Development Coordinator will educate staff on dignity, including assisting residents to change clothing after meals if they are soiled.	

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F 241	Continued From page 2 his/her abdomen. The CNA transferred the resident from his/her wheelchair to the recliner chair and departed without removing the stained shirt. Continuous observation from 8:20 AM until 11:25 AM revealed the resident continued to wear the shirt until it was removed and replaced at 11:25 AM. 4. Interview with CNA #1 on 1/9/14 at 10:25 AM revealed residents should have their clothes changed or cleaned when staff notice dirty clothing after a meal. 5. Periodic observation on 1/6/14 through 1/8/14 showed resident #6 was located in a room posted with contact precautions signage; the posted precautions required staff and visitors to use PPE, practice stringent hand hygiene procedures, and generally diminish the resident's freedom to move about the facility as a consequence of an epidemiologically significant condition. Interview with RN #1, who was also the IP, on 1/6/14 at 3:10 PM confirmed the resident was on transmission-based precautions as a result of unresolved infection. The RN stated the facility was waiting for laboratory confirmation that the resident was no longer infective. Review of the resident's medical record on 1/7/14 uncovered laboratory test results dated 12/27/13 (11 days prior) showing the resident was negative for the infectious agent based on molecular amplification test methods used in the laboratory. When asked by the surveyor about the test results, the IP stated she was not familiar with molecular test methods and misunderstood the results; she acknowledged the resident was asymptomatic and, along with the laboratory diagnostic information in the medical record, could have been released from contact precautions "...a	F 241	The Staff Development Coordinator or designee will round on residents with isolation precautions three times per week to review cases, including review of laboratory work, to determine continued need for isolation. If isolation precautions are no longer needed precautions will be removed and care plan amended to reflect the changes. **Monitoring:** The Director of Nursing or designee will complete random visual dignity observation audit of 10 residents 3 times weekly for 90 days. The audit will include checking that resident, resident clothing and wheelchair are clean after meals. Corrective actions will be taken as needed for any identified concerns. The Director of Nursing or designee will review residents with isolation precautions weekly for 90 days to ensure appropriate interventions are in place. Corrective actions will be taken as needed. The Director of Nursing will track and trend the results of the dignity audits monthly and report findings to the QAPI committee monthly. The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need	

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F 241	Continued From page 3 couple of days ago." Telephone interview with the manager of the testing laboratory on 1/7/14 at 4:10 PM confirmed the test report indicated a negative result.	F 241	for continued monitoring based on compliance.	
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and review of resident council meeting minutes, the facility failed to effectively act on grievances related to meal service for 3 of 3 consecutive months (October, November, December 2013). The findings were: Review of the Resident Council minutes from October, November, and December 2013 revealed the residents attending the meetings had complained about the system of meal service and the amount of time they were waiting. Review of these meeting minutes showed "...early arrivals seem to wait a long time for meals...Dietary: still concerned about the wait time:..Dietary: time concerns." The minutes also showed the residents made the suggestion to start meal service earlier or at least serve the meals at the time posted. The following concerns were identified: a. During the group interview on 1/7/14 at	F 244	**F244** It is the practice of the facility to listen to the views of the residents and act upon the grievances and recommendations of the residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. **Corrective Action:** a) At a Resident Council meeting held on 1/23/2014, the resident's discussed their concerns with the wait time for meals. Residents gave input and suggestions to reduce dining wait times. Facility staff will report interventions to the residents individually and at the next Resident Council meeting to ensure their concerns are resolved. b) The Dietary Manager, Director of Nursing and Activities Director met on 1/13/2014 to formulate plan for dining service improvement. Plan will be implemented by 2/14/2014. c) At the facility QAPI meeting held on 1/20/2014, a Performance Improvement Plan was developed to address the residents' concerns with dining wait time.	2/14/2014 2/19/14 gb

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F 244	Continued From page 4 11 AM, six residents agreed they were still waiting too long to receive meals. One resident stated "We have to wait sometimes 2 hours for our food." The resident revealed "We go to the dining room early so we can get a chair and then we have to wait to get our food." b. Review of the follow-up documentation showed the dietary department responded to the residents' complaint. Follow-up actions taken in December 2013 included dietary staff monitoring the punctuality of food being ready at the posted meal times. However, the form further showed that although the food was ready in the kitchen, follow-up from nursing was needed to promptly serve the meals to the residents. There was no evidence to show this action was completed or that nursing was aware their reply was needed. c. Interview with the administrator on 1/9/14 at 10 AM revealed she was aware of the residents concerns regarding the wait for meals. She further stated that potential solutions had been discussed with multiple departments including nursing, but none had been implemented at that time.	F 244	**Identification of Others:** During Resident Council, residents were asked to identify any other concerns they would like the staff to address. Activities Director will interview residents able to be interviewed to identify any other concerns. **Systemic Changes:** Concerns brought through the Resident Council will be addressed in Morning Meeting the day following the council meeting. An Ad Hoc QAPI Performance Improvement Plan will be developed and implemented in the morning meeting. The plan and any outcomes will be reported back to the residents at the next Resident Council Meeting. If Residents are not satisfied with the resolution, further input from the Residents will be sought and adjustment made to the Performance plan accordingly, until a satisfactory resolution is reached.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a variety of items in 6 of 6 resident areas (the secure unit and 100, 200, 300, 400, 500, and 600 hallways) were clean and	F 253	The Performance Improvement Plan developed in QAPI on 1/20/2014 will be used to resolve the residents' concern with dining wait times. The plan involves an extended meal service time for all 3 meals, as well as additional dining space within the facility. Additional activities before meals and nursing staff not bringing resident's to dining room too early, are also addressed in the performance plan.	

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F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a variety of items in 6 of 6 resident areas (the secure unit and 100, 200, 300, 400, 500, and 600 hallways) were clean and	F 253		

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F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a variety of items in 6 of 6 resident areas (the secure unit and 100, 200, 300, 400, 500, and 600 hallways) were clean and	F 253	**F253** It is the practice of the facility to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. **Corrective Action:** 1a) Upholstered recliners in the secure unit television area were cleaned.. 1b) Bathroom floors in resident rooms; #303, #304, #305, #306, #309, #409, #414, #507, and #509 were cleaned to remove sticky residue and stains. In addition, bathroom floors in resident	

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F 253	Continued From page 5 well maintained. The findings were: 1. Interview with the housekeeping supervisor on 1/8/14 at 11:20 AM verified the following items were in need of additional cleaning, and the bathroom floors were damaged and no longer a cleanable surface: a. Observation on 1/6/14 at 4:45 PM showed two upholstered recliners in the secure unit television area that were soiled. The recliners had dried whitish and brownish substances on the arms, backs and seats of the chairs. Observation on 1/9/14 at 10:20 AM showed the recliners had still not been cleaned. b. Observation on 1/7/14 beginning at 8:40 AM revealed the following resident bathroom floors were sticky when stepped on, and dirty with brownish and/or blackish stains: #303, #304, #305, #306, #309, #409, #414, #507, and #509. Observation on 1/7/14 from 1:10 PM to 1:45 PM revealed the following resident bathroom floors were sticky when stepped on, and dirty: #206, #208, #502, #505, #513, #102, #104, #107, #113, and #116. c. Observation on 1/7/14 beginning at 8:40 AM revealed the following floors were dirty: Room #305 had blackish stains in the entryway. Room #309 had coffee-like stains on the floor. Room #113 by the first bed had dirty adhesive remaining on the floor from 6 strips that had been removed. 2. Interview with the maintenance supervisor on 1/8/14 verified the following items were in need of repair, and the facility failed to have a specific plan with a timeframe for those repairs: a. Observation in the secure unit on 1/6/14 at 4:45 PM showed a hand washing sink and cabinet located in the main area near the nurses' desk. The top drawer of the cabinet was missing	F 253	rooms; #206, #208, #502, #505, #513, #102, #104, #107, #113, and #116 were cleaned. 1c) Stain on floor in room #305 was removed. Coffee-like stain on floor in room #309 was removed. Adhesive remaining on floor of room #113 could not be removed. Tile will be replaced in that section of the floor. 2a)Cabinet of the hand washing sink on SCU has been repaired. 2b) The bathroom floor in rooms #404, #303, #208, #502, #114, and #104 will be resurfaced. The crack in the floor outside of secure unit tub room will be repaired. The hall floor outside room #505 will be repaired. 2c) The door of room #414 will be repaired. The sink cabinet of room #312 will be replaced. The wallpaper in room #306 will be repaired. The door frame of room #309 will be repainted. Door frame of room #208 will be repainted. The kick plate on the front door of room #206 will be reattached. The kick place on the secure unit utility room door will be replaced. The heat vent in the bathroom of room #512 will be repaired. The bathroom door of room #103 will be repaired. The door frame to the bathroom of room #602 will be repainted. The scrape in the wall of room #601 will be repaired.	

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F 253	Continued From page 6 its front and it appeared to have been broken away. Periodic observation revealed the drawer remained in this condition throughout the survey (1/6/14 - 1/9/14). b. Observation on 1/7/14 beginning at 8:40 AM revealed the following linoleum floors were cracked and could not be adequately cleaned: The bathroom floor in room #404 had a 3 foot 3 inch crack along the right edge, the bathroom floor in room #303 had a 4 foot 7 inch crack along the left side. Observation on 1/7/14 from 10:40 AM to 11:20 AM revealed the following linoleum floors were cracked: The hall floor outside of the secure unit tub room had a 5 foot 6 inch crack. The hall floor outside of room #505 had a 12 inch crack. The bathroom floor in room #208 had 3 foot 1 inch crack on the right side. The bathroom floor in room #502 had a 21 inch crack on the right side. The bathroom floor in room #114 had a 13 inch crack on the left side of the floor. The bathroom floor of room #104 had a crack on the right side of the floor that was 12 inches long. c. Observation on 1/7/14 beginning at 8:40 AM revealed the following wall, door, and room damage: The front door of room #414 had been damaged from the bottom hinge with splintered wood that measured 19 inches in height. The sink cabinet of room #312 had a 3 and a half inch by 2 inch hole on the left side, and multiple chips in the paint. The back wall of room #306 had wallpaper separated from the wall from 2 feet from the floor to 4 feet in height. The front door frame to room #309 had the paint scraped off from the floor to 3 feet 1 inch in height. The left side of the door frame of room #208 had scraped paint from the floor up to 3 feet 1 inch in height. The kick plate on the front door of room #206 was pulled loose on the inside by the hinges from the bottom of the door up to 19 inches in height. The kick plate to	F 253	2d) The caulking around the base of the toilets in resident rooms #505, #106, #608, and #610 will be removed and replaced with fresh caulking. The Administrator provided in-service to staff on 1/30/2014 concerning the proper way to communicate housekeeping and maintenance concerns using a heat ticket method. Staff was also asked to assist the Housekeeping and Maintenance Departments in identifying areas in need of attention. **Identification of Others:** The Maintenance Supervisor or Designee will conduct an audit of facility doors, door frames, kick plates, walls, toilet bases, cabinets, heat vents and floors to identify areas in need of repair. Results of the audits will be reviewed with the NHA and prioritized and scheduled for repairs. The Housekeeping Supervisor or Designee will conduct an audit of all resident room floors and bathroom floors to identify areas needing additional cleaning or stain removal. The audits will be reviewed with the NHA and areas cleaned as needed. **Systematic Changes:** The Maintenance Supervisor or Designee will develop a performance improvement plan to prioritize renovation projects in the facility. The Maintenance Department	

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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 01/09/2014

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 263	Continued From page 7 the secure unit utility room was chipped off on the bottom right corner 6 inches across. The bathroom of room #512 had a heat vent that was rusted 27 inches across. The bathroom door of room #103 had 3 gashes on the outer door. Each gash measured 36 inches. The door frame to the bathroom of room #602 had paint scratched off on the right from the floor to 33 inches in height. In room #601 by the right wall there was a scrape that was 46 inches long. d. Observation on 1/7/14 at 1:45 PM revealed the base of the toilet in the bathroom of room #505 had a rusty and dirty appearance. Observation on 1/8/14 at 11:20 AM revealed the following bathrooms had toilets with a rusty and dirty looking base: #106, #608, and #610.	F 253	will follow the TELS schedule for routine maintenance. The Housekeeping Supervisor or Designee will audit the facility 3 times per week to ensure floors are clear of sticky residue and stains. The Housekeeping Supervisor will inspect recliners once per week for cleanliness and ensure cleaning is done if needed. The Administrator or Designee will round the facility weekly to ensure that cleaning and maintenance projects are being completed and outcomes are satisfactory.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279	**Monitoring:** The Maintenance Supervisor or designee will track and trend the results of the maintenance audits that were conducted with the NHA monthly and report the findings to the QAPI committee monthly. The Housekeeping Supervisor will report the results of weekly audits to the QAPI committee monthly for three months. The QAPI committee will evaluate effectiveness of the plans based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance. 2/19/14 2/14/2014	

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F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279	**F279** It is the practice of the facility to use results of the assessment to develop, review and revise the resident's comprehensive plan of care. **Corrective Action:** Resident #28's nutrition and ADL care plan were updated to address the resident's need for large handled silverware. The need for large handled silverware was also added to resident #28's tray card. Also added to the care plan were the various levels of dressing assistance needed. Resident #19's incontinence and ADL care plan were updated to address resident's need for mechanical lift for transfers and use of toilet in shower room for toileting. added via phone request HA. 2/13/14 3:30 pm	

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F 279	Continued From page 8 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of resident medical records, the facility failed to develop accurate and individualized care plans for 4 (#6, #19, #20, #28) of 20 sample residents. The findings were: Review of care plans for sample residents on 1/7/13 through 1/9/13 revealed care plans for 4 (#6, #19, #20, #28) sample residents were inaccurate or failed to include comprehensive and individualized descriptions of resident(s) care needs. The following discrepancies were identified: 1. Review of the 12/2/13 physician signed order recapitulation showed resident #28 had orders for a regular, mechanical soft texture diet with large handle silverware to be used. Review of the 10/8/13 quarterly MDS assessment showed the resident required extensive assistance with eating. Observation on 1/8/14 at 7:40 AM showed the resident was feeding him/herself hot cereal with a regular spoon. CNA #1 sat next to the resident to provide assistance to the resident as needed and others at the table. Interview with cook #2 at 7:43 AM revealed there was not any large handled silverware available in the secure unit kitchen. Interview with CNA #1 at 7:45 AM revealed the resident did not always feed him/herself and she was unaware of large handled silverware ever being provided for the resident to use. Review of the nutrition care plan last reviewed on 12/9/13 showed the use of large handled silverware was not included as an	F 279	A care plan was written for resident #6 to address infection. The care plan included condition requiring precautions, type of infection prevention precautions and criteria for ending precautions. A care plan was written for resident #20 to address infection. The care plan included condition requiring precautions, type of infection prevention precautions and criteria for ending precautions. **Identification of Others:** An audit of care plans of residents who require adaptive equipment at meals, who have specialized needs r/t toileting and who have infections will completed by 2/6/14 by Director of Nursing or designee to determine if these areas are addressed. Care plans will be updated as needed based on audit findings. An audit of dietary tray cards will be completed by the Dietary Manager to determine if adaptive equipment is indicated. Tray cards will be updated as needed based on findings. **Systematic Changes:** The Staff Development Coordinator or designee will educate licensed nurses on updating care plans to reflect resident's needs for adaptive equipment at meals, specialized toileting needs, and infection control.	

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F 279	Continued From page 9 intervention. Further, the care plan failed to show the resident's required and variable level of assistance with meals. 2. Observation on 1/7/14 at 9:12 AM showed CNAs #1 and #2 used the secure unit shower room to toilet resident #19. The resident required a sit-to-stand mechanical lift to transfer from the wheelchair to the toilet. Interview with the CNAs at that time revealed they used the shower room due to this resident's roommate (#28) who had impulsive behaviors that caused safety risks to both residents when the bathroom was in use in the shared room. The following concerns were identified: a. Review of the 7/10/13 care plan related to incontinence and ADLs for resident #19 failed to show the resident used a mechanical lift for transfers. In addition, the care plan failed to show the resident was to be toileted in the secure unit shower room. b. Review of the care plan for resident #28 failed to show how this resident's behavior impacted the roommate. The care plans related to incontinence, ADLs and falls were reviewed and provided no details regarding the bathroom issue referred to by the CNAs. 3. Observation while touring the facility on 1/6/14 beginning at 1:45 PM revealed 3 resident rooms posted with transmission-based precautions. Review of resident care plans for these residents on 1/7/14 beginning at 10:50 AM revealed 2 residents (#6 and #20) lacked any information in their care plan to indicate infection prevention precautions were in place, conditions requiring precautions, criteria for ending infection prevention precautions, or any special conditions or goals for the residents impacted by the	F 279	The Staff Development Coordinator or designee will educate the interdisciplinary team to the interdisciplinary team on updating care plans to reflect resident's needs. The Dietary Manager will educate dietary staff on reading tray cards and providing adaptive equipment at meals as indicated. The 24 hour report, new telephone orders and new physician orders and therapy communication tools will be reviewed 3 times per week at morning interdisciplinary team meeting by Director of Nursing or designee. Care plans will checked after meeting to determine if new or changes in infections, adaptive equipment and specialized toileting needs are addressed. **Monitoring:** A random audit of 10 care plans per week for adaptive equipment with meals, specialized toileting needs and infection control will be completed weekly on current residents by the Director of Nursing or designee for 3 months. An audit will be completed weekly for 3 months by the Director of Nursing or designee to review care plans for new admissions / re-admissions and residents with changes in ADL's and new infections. Corrective actions will be taken as needed for based on audit findings.	

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F 279	Continued From page 10 precautions. The IP confirmed in interview on 1/8/14 at 3:20 PM that the 2 residents cited lacked care plan updates to reflect the current infection control precautions.	F 279	A random audit of 10 tray cards per week for adaptive equipment that is needed with meals will be completed by the Dietary Manager for 3 months. The audit will include observation of whether adaptive equipment is provided with meal service. Corrective actions will be taken as needed based on findings. The Director of Nursing will track and trend the results of the care plan audits and report findings to the QAPI committee monthly. The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need	2/14/2014 2/19/14
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure the care plan was followed as written for 1 of 20 sample residents (#28). The findings were: Review of the 7/29/13 care plan showed resident #28 was at a risk of falls due to a history of falls, mental status, decreased muscle coordination, change in gait pattern, arthritis, narcotic use, psychotropic drug use and a diagnosis of Huntington's disease. The care plan showed interventions of placing the bed in low position dated 9/18/13, and for staff to assist with transfers and ambulation using a gait belt dated 10/14/13. The following concerns were identified: a. Observation on 1/7/14 at 11:30 AM showed the resident was laying in bed, and the bed was not in a low position. Interview with CNAs #1 and #2 at that time verified the bed was not in the low position and CNA #1 lowered the bed approximately 6 inches. Both CNAs stated they were not aware of this care plan intervention. b. Observation on 1/8/14 at 7:50 AM showed	F 282		

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F 279	Continued From page 10 precautions. The IP confirmed in interview on 1/8/14 at 3:20 PM that the 2 residents cited lacked care plan updates to reflect the current infection control precautions.	F 279	**F282** It is the practice of the facility that services provided or arranged by the facility be provided by qualified persons in accordance with each resident's written plan of care.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and medical record review, the facility failed to ensure the care plan was followed as written for 1 of 20 sample residents (#28). The findings were: Review of the 7/29/13 care plan showed resident #28 was at a risk of falls due to a history of falls, mental status, decreased muscle coordination, change in gait pattern, arthritis, narcotic use, psychotropic drug use and a diagnosis of Huntington's disease. The care plan showed interventions of placing the bed in low position dated 9/18/13, and for staff to assist with transfers and ambulation using a gait belt dated 10/14/13. The following concerns were identified: a. Observation on 1/7/14 at 11:30 AM showed the resident was laying in bed, and the bed was not in a low position. Interview with CNAs #1 and #2 at that time verified the bed was not in the low position and CNA #1 lowered the bed approximately 6 inches. Both CNAs stated they were not aware of this care plan intervention. b. Observation on 1/8/14 at 7:50 AM showed	F 282	**Corrective Action:** Resident #28's plan of care for falls will be reviewed and updated as needed by the Director of Nursing or designee. Based on care plan update the C.N.A. assignment sheets will be updated to reflect fall intervention.. Staff who are routinely assigned to care for resident #28 will be education on her plan of care for falls by the Staff Development Coordinator. **Identification of Others:** An audit of care plans of residents who are at risk for falls will completed by Director of Nursing or designee to determine if interventions meet residents current level of care. Care plans will be updated as needed based on audit findings. C.N.A. assignment sheets will be updated to reflect current fall interventions. **Systematic Changes:** The Staff Development Coordinator or designee will educate nursing staff on following interventions in care plans for falls.	

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F 282	Continued From page 11 the resident got up independently from the dining chair and ambulated across the room to the secure unit kitchen to make a request and then without any assistance ambulated back to the dining chair and sat down. At that time CNA #1 was seated at the table with the resident, and an occupational therapist was in the vicinity assisting with meals. During the observation, neither staff member attempted to assist the resident with transfer or ambulation. c. Interview with the DON on 1/8/14 at 12 PM verified the care plan should be followed and also revealed the interventions for this resident needed to be reviewed to ensure it met the resident's current level of care.	F 282	The CNA assignment sheets will be brought to morning interdisciplinary meeting, care conferences and weekly risk management meetings by the Director of Nursing or designee and updated as care plan is updated. Changes in care plans that affect care provided by CNA's will be reviewed with CNA's at daily "Huddle" as needed. **Monitoring:** A random visual observation audit of 10 residents per week will be conducted by the Director of Nursing or designee for 3 months to determine if care planned interventions for falls are being followed. Corrective actions will be taken as needed for based on audit findings. The Director of Nursing will track and trend the results of the adherence to care plan audits and report findings to the QA&A committee monthly. The QA&A committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	2/14/2014 2/19/14
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR 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 medical record review and staff interview, the facility failed to ensure an effective bowel monitoring system was implemented for 1 of 2 sample resident (#29) who required this type of monitoring. The findings were: Review of the 12/1/13 quarterly MDS for resident #29 showed the resident required limited assistance with toileting, was continent of bowel	F 309		

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F 282	Continued From page 11 the resident got up independently from the dining chair and ambulated across the room to the secure unit kitchen to make a request and then without any assistance ambulated back to the dining chair and sat down. At that time CNA #1 was seated at the table with the resident, and an occupational therapist was in the vicinity assisting with meals. During the observation, neither staff member attempted to assist the resident with transfer or ambulation. c. Interview with the DON on 1/8/14 at 12 PM verified the care plan should be followed and also revealed the interventions for this resident needed to be reviewed to ensure it met the resident's current level of care.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR 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 medical record review and staff interview, the facility failed to ensure an effective bowel monitoring system was implemented for 1 of 2 sample resident (#29) who required this type of monitoring. The findings were: Review of the 12/1/13 quarterly MDS for resident #29 showed the resident required limited assistance with toileting, was continent of bowel	F 309	**F309** It is the practice of the facility that each resident receive and the facility provides 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. **Corrective Action:** The Director of Nursing or designee will complete a bowel / bladder 7 day tracking and then review and update bowel / bladder assessment as needed for resident #29. Based on results of assessment resident #29's bowel regimen will be reviewed and plan of care will be updated to reflect interventions for bowel management.	

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F 309	Continued From page 12 and had severe cognitive impairment. Review of 11/7/13 care plan showed interventions included observe for bowel pattern to ensure adequate bowel elimination to address problem of constipation. Review of the physician's orders showed Milk of Magnesium (a laxative) with prune juice was ordered on 10/7/13 and bisacodyl (a laxative) 5 milligrams and instructions to implement the bowel protocol was ordered on 10/10/13. Review of the bowel protocol revealed the following instructions: a. Give Milk of Magnesia at bedtime on third day with no bowel movement. b. If no bowel movement the next day then give bisacodyl 5 milligrams. c. If no bowel movement by the next day then give a 10 milligram bisacodyl suppository. During an interview on 1/8/14 at 8:30 AM, RN #3 revealed the system for monitoring whether or not the resident had a bowel movement within 3 days consisted of daily documentation in the "Care Tracker" computer database. Review of the documentation in the Care Tracker computer database revealed the resident did not have a bowel movement during the following days: 10/20/13 to 10/23/13 (4 days), 10/29/13 to 11/1/13 (4 days), 11/3/13 to 11/12/13 (10 days), 11/15/13 to 11/24/13 (9 days), 11/26/13 to 12/8/13 (12 days), 12/10/13 to 12/29/13 (19 days), and 12/31/13 to 1/6/14 (6 days).	F 309	**Identification of Others:** The Director of Nursing or designee will review bowel elimination documentation for the past month to identify any residents with no documentation of bowel movement for 4 or more days. For those identified bowel regimen will be reviewed and changes made as needed. **Systematic Changes:** The Staff Development Coordinator or designee will educate licensed nurses on bowel management including bowel movement documentation and daily review, bowel protocol, physical assessment and follow up for anyone who has not had a bowel movement in past 3 days. The Director of Nursing or designee will initiate a worksheet for C.N.A.'s to record bowel movements every shift. This worksheet will be completed for 3 months in addition to Care Tracker documentation of bowel movements. When discrepancies in Care Tracker documentation are resolved the form will be discontinued.	
	Review of the 2013 October, November, and December medication administration records (MARS) showed a laxative medication was administered only on 12/2/13 and 12/26/13. Further review of the MARS showed none was administered from 1/1/14 to 1/6/14.		The Staff Development Coordinator or designee will educate C.N.A.'s on documentation of bowel movements in Care Tracker and on bowel movement worksheet..	

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F 309	Continued From page 13 Interview with the DON and RN #1 on 1/9/13 at 10:15 AM revealed a nursing assessment confirmed the resident was not currently having problems with constipation. However, they further stated the "Care Tracker" database had malfunctioned and needed to be repaired to correct the errors in the current bowel monitoring system.	F 309	**Monitoring:** The Director of Nursing or designee will complete audit of documentation of bowel movements and interventions taken if no bowel movement recorded in 3 days. Corrective action will be taken as needed. The audit will be completed 2 times weekly for 3 months. The Director of Nursing will review the audits of bowel management for trends and report monthly to the QAPI Committee. The QAPI Committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance, monthly x3 months. The QAPI Committee will then determine if any further action is required.	2/14/2014 2/19/14
F 312 SS=D	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 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff, resident and family interview, the facility failed to ensure 1 of 17 sample residents (#58) and 2 non sample residents (#2, #96) who required assistance with ADLs were provided the needed assistance related to grooming and personal hygiene. The findings were: 1. Review of the medical record showed resident #2 was admitted with a diagnoses of frontal lobe dementia on 9/18/13. Review of the 12/27/13 quarterly MDS assessment revealed the resident required limited assistance with one person physical assistance for personal hygiene and for bathing. Review of a nurses' note dated 1/4/14 timed 7 AM - 7 PM showed the resident's family member was requesting the resident be provided a shower, a shave and a haircut. The note further	F 312		

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	535024	A. BUILDING _____ B. WING _____	C 01/09/2014

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 13 Interview with the DON and RN #1 on 1/9/13 at 10:15 AM revealed a nursing assessment confirmed the resident was not currently having problems with constipation. However, they further stated the "Care Tracker" database had malfunctioned and needed to be repaired to correct the errors in the current bowel monitoring system.	F 309		
F 312 SS=D	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 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff, resident and family interview, the facility failed to ensure 1 of 17 sample residents (#58) and 2 non sample residents (#2, #96) who required assistance with ADLs were provided the needed assistance related to grooming and personal hygiene. The findings were: 1. Review of the medical record showed resident #2 was admitted with a diagnoses of frontal lobe dementia on 9/18/13. Review of the 12/27/13 quarterly MDS assessment revealed the resident required limited assistance with one person physical assistance for personal hygiene and for bathing. Review of a nurses' note dated 1/4/14 timed 7 AM - 7 PM showed the resident's family member was requesting the resident be provided a shower, a shave and a haircut. The note further	F 312	**F312** It is the practice of the facility to ensure that 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. **Corrective Action:** Resident #2 received nail care, a bath, shave, hair care. Resident #2's plan of care for personal hygiene and grooming will be reviewed by the Director of Nursing or designee and amended as needed. A 1:1 education will be completed with nursing staff that routinely provide care to resident #2 on personal hygiene needs and interventions. Resident #96 received nail care. Resident #96's plan of care for personal hygiene and grooming will be reviewed by the Director of Nursing or designee and amended as needed. A 1:1 education will be completed with nursing staff that routinely provide care to resident #96 on personal hygiene needs and interventions.	

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F 312	Continued From page 14 showed the family would bring in an electric razor for the resident to use with staff supervision. The following concerns were identified: a. Observation on 1/8/14 at 10:35 AM showed the resident was at the nurses' desk requesting to see the razor brought in by his/her family. The resident's family member was also present. At that time it was noticed the resident had facial hair growth and also had long fingernails. b. Interview with the resident on 1/8/14 at 10:35 AM revealed s/he hadn't been shaved for a couple of days, and the family member verified it was last done at the barber shop on 1/4/14. The family member then stated he brought the electric razor in today (1/8/14) and it was given to the nurse for safe keeping. The resident was anxious to see and use the electric razor. The resident interview further revealed the resident's nails had not been cut for a "long time" and "I could do it myself, but I don't have the tools." c. Interview with LPN #1 on 1/8/14 at 10:45 AM verified the resident's nails should be trimmed by the CNAs. The nurse stated the resident could not keep his/her own clippers for safety reasons. The nurse then stated nails were to be done on bath days and was not certain why they had gotten so long. Further, the nurse verified facial shaving was to be done on bath days and more frequently per the resident's preference. 2. Review of the 11/12/13 admission MDS showed resident #96 required supervision with one person physical assistance for personal hygiene and extensive assistance with one personal physical assistance for bathing. Observation on 1/7/14 at 1:15 PM showed the resident had long fingernails on both hands. The resident was not able to make him/herself understood when asked about nail care. Review	F 312	Resident #58 received shave. Resident 58's plan of care for personal hygiene and grooming will be reviewed by the Director of Nursing or designee and amended as needed. A 1:1 education will be completed with nursing staff that routinely provide care to resident #58 on personal hygiene needs and interventions. **Identification of Others:** The Director of Nursing or designee will complete a visual observation audit of residents to determine any unmet personal hygiene needs, including nail care, grooming, bathing, shaving, hair care and clean clothing. For any concerns identified the Director of Nursing or designee will assess cause and take corrective action as appropriate. **Systematic Changes:** The Staff Development Coordinator or designee will educate the nursing staff on proper hygiene including nail care, grooming, bathing, shaving, hair care and clean clothing. **Monitoring:** The Director of Nursing or designee will complete visual observation audits of personal hygiene 3 times weekly on a random sample of 10 residents. The personal hygiene audit will include nail care, grooming, shaves, hair care, bathing and cleanliness of clothes. Corrective action will be taken as appropriate for any concerns identified.	

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F 312	Continued From page 15 of the 11/13/13 resident care plan for ADLs showed the resident required a varied level of assistance ranging from supervision to extensive assistance. However, the care plan failed to show a plan related to bathing and nail care. 3. Review of the medical record showed resident #68 had a diagnosis of Alzheimer's dementia. According to the 12/15/13 quarterly MDS assessment, the resident required limited assistance with 1 person physical assistance for personal hygiene. Review of the resident's care plan dated 9/4/13 showed need for extensive assistance utilizing 2 staff members for ADL's. Observation on 1/7/14 at 9:30 AM, and again on 1/8/14 at 10 AM, revealed the female resident had numerous chin hairs which were easily visible. Interview with CNA #4 on 1/7/14 at 10 AM revealed the resident had noticeable chin hairs that should have been shaved when the resident received her bath on Wednesday or Saturday.	F 312	The Director of Nursing will track and trend the results of the personal hygiene audits and report findings to the QAPI committee monthly. The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance. 2/14/2014 2/19/14 JB	
F 323 SS=G	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, medical record review,	F 323	**F323** It is the practice of the facility to ensure that the resident environment remains free of accident hazards, as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. **Corrective Action:** Resident #16 received care for burns per doctor's orders until resolved.	

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F 323	Continued From page 18 installed on 1/7/14 was planned due to a contract change. f. Interview on 1/8/14 at 6:45 AM showed dietary aide #1 checked the facility coffee temperature. The temperature was 125 degrees F, and at that time the aide stated any temperature above 160 degrees F was a potential hazard for residents. 2. Observation in the following areas showed heat vents with exposed metal edges that had the potential for injury: a. Observation on 1/7/14 at 10:40 AM showed the bathroom heat vent in room #507 was loose with the middle metal clamp jutting outward 13 inches revealing a 6 inch sharp edge. b. Observation on 1/7/14 at 11:40 AM revealed the secure unit sun room heat vent was loose from the wall 53 inches across with a sharp metal edge pointing outward. c. Observation on 1/7/14 at 1:45 PM showed the bathroom heat vent in room #504 was loose with the middle metal clamp jutting outward 15 inches revealing an 8 inch sharp edge. d. Observation on 1/8/14 at 11:20 AM showed the bathroom heat vent in room #602 was loose from the wall 6 feet across revealing a sharp metal edge across the entire vent. Interview with the maintenance supervisor on 1/8/14 at 2:20 PM confirmed heat vents were in disrepair. He further stated the facility planned to update the entire heating system. However, the facility failed to have a specific plan to address this issue.	F 323	**Identification of Others:** 1) Dietary Manager audited the temperature of the coffee pot in the secure unit kitchenette. 2) The Maintenance Supervisor and Assistant conducted an audit of the facility heat vents to identify unsafe conditions. **Systemic Changes:** 1) All hot beverages served to residents will be served from air pots. Dietary staff will check temperature of all air pots before putting them into service to residents. The serving temperature of hot beverages will not exceed 150 degrees. 2) The Dietary Staff will be educated by the Dietary Manager or designee on proper serving temperatures for hot beverages and checking temperatures in air pots before placing them for resident use. 3) The Staff Development Coordinator will educate staff on resident safety with hot beverages. 4) The Maintenance Supervisor or Designee will conduct safety	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 323	Continued From page 18 installed on 1/7/14 was planned due to a contract change. f. Interview on 1/8/14 at 6:45 AM showed dietary aide #1 checked the facility coffee temperature. The temperature was 125 degrees F, and at that time the aide stated any temperature above 160 degrees F was a potential hazard for residents. 2. Observation in the following areas showed heat vents with exposed metal edges that had the potential for injury: a. Observation on 1/7/14 at 10:40 AM showed the bathroom heat vent in room #507 was loose with the middle metal clamp jutting outward 13 inches revealing a 6 inch sharp edge. b. Observation on 1/7/14 at 11:40 AM revealed the secure unit sun room heat vent was loose from the wall 53 inches across with a sharp metal edge pointing outward. c. Observation on 1/7/14 at 1:45 PM showed the bathroom heat vent in room #504 was loose with the middle metal clamp jutting outward 15 inches revealing an 8 inch sharp edge. d. Observation on 1/8/14 at 11:20 AM showed the bathroom heat vent in room #602 was loose from the wall 6 feet across revealing a sharp metal edge across the entire vent. Interview with the maintenance supervisor on 1/8/14 at 2:20 PM confirmed heat vents were in disrepair. He further stated the facility planned to update the entire heating system. However, the facility failed to have a specific plan to address this issue.	F 323	audits of the facility heating vents quarterly per the TELS schedule. Any identified issues will be corrected in a timely manner. **Monitoring:** 1) The Dietary Manager or designee will complete random audits of hot beverage temperatures in air pots 3 times per week for 3 months to validate beverages are served at a safe temperature. The audit will include checking temperature documentation completed by dietary staff. 2) The Dietary Manager or Designee will report results of the hot beverage audits to the QAPI meeting each month. 3) The Maintenance Supervisor or Designee will report the results of the heat vent audit to the Safety Committee meeting according to the TELS schedule. 2/14/2014 2/19/14 LB	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371	**F371** It is the practice of the facility to (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.	

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F 323	Continued From page 16 staff interview, and review of facility incident reports, the facility failed to ensure resident safety concerning hot beverages for 1 (#16) of 70 residents who were known to consume hot beverages. In addition, the facility failed to promote a safe and accident-free environment in 3 resident rooms (#505, #507, #602) and 1 of 6 resident areas (secure unit). The findings were: 1. Review of an incident report concerning resident #16 showed the resident sustained burns from spilling hot chocolate into his/her lap on 12/24/13. The hot chocolate was served to the resident by staff. Review of the incident details showed the burn was described as a 15 millimeter (mm) by 9 mm reddened area to the left thigh, and a 15 mm by 17 mm reddened area to the right thigh. The notes showed the facility staff removed the resident's pants at the time the beverage was spilled and placed a cool compress to the reddened areas. Further review showed the physician was notified by voice mail at that time, and staff documented the plan to monitor the burn until resolved. Observation on 1/6/14 at 5:16 PM revealed RN #4 provided wound care for open areas on the resident's inner thighs. At that time the areas were bleeding. Review of physician signed orders on 1/7/14 showed "Keep clean dry...monitor until healed...burn healing...no evidence of infection." The following concerns were identified with the facility's accident prevention: a. Interview with the administrator and DON on 1/9/14 revealed after the incident the facility changed the way hot chocolate was dispensed. When the burn occurred the hot chocolate was dispensed from a machine into the cup. The change included the hot chocolate being poured into carafes prior to meals and allowed to sit prior	F 323	1a) All hot beverages are served from air pots. Temperature of hot liquids is checked by dietary staff prior to serving. Serving temperature is at 150 degrees or less. 1b) Resident #16 was provided occupational therapy for hand and arm strengthening to improve ability to self-manage drinking from a cup. Hot beverage cups with lids were provided to resident #16 and one additional resident, who was identified to be at risk. In addition, both identified residents' wheelchairs were fitted for cup holders to improve safe transport of hot beverages. Both residents refuse to use adaptive equipment provided. 1c) The hot chocolate machine was removed from dining area. Hot beverage air pots are used to dispense hot chocolate. The temperature of the hot water in the air pot used to make the cocoa is measured by the dietary staff prior to serving residents. 1d) The new coffee machine was installed to better help regulate the temperature of coffee served to residents. However, the hot water dispenser handle had to be removed, because no guard was present to prevent accidental dispensing of hot water.	

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F 323	Continued From page 17 to being poured into resident cups. In addition, a plan was developed to monitor the temperatures of the hot chocolate; however, this monitoring was not accomplished due to frequent staff changes in the dietary department. b. Review on 1/9/14 of the completed incident investigation related to the spilled hot chocolate showed the facility ordered cups with lids on 1/8/14 (15 days after the resident was burned) to secure hot beverages for 2 residents identified as needing lids for hot drinks, which included resident #16. c. On 1/7/14 at 9:40 AM a surveyor checked the temperature of a cup of coffee taken from a coffee machine in the main dining room used by residents; the temperature was 168 degrees Fahrenheit (F). Thirty minutes later the temperature of a second cup of coffee from the same machine was checked and found to be 165 degrees F. Observation on 1/7/14 at 5 PM showed the facility was installing a new coffee machine at that time. d. Interview with the regional dietary supervisor on 1/8/14 at 11:30 AM revealed the new coffee dispenser which was installed on 1/7/14 was ordered due to a change in contracts. The supervisor further revealed this machine was better because the temperature could be adjusted and controlled. When asked what temperature was appropriate the supervisor revealed they set the temperature to 150 degrees F. e. Interview on 1/9/14 at 8:30 AM with the administrator, DON, and RN #1 confirmed they had started taking and controlling temperatures of hot beverages on 1/8/14. This was based on installation of the new coffee machine and their discussion with the regional dietary supervisor. They further acknowledged the new coffee pot	F 323	1e) In order to assure the safety of the residents, the new coffee machine was move inside the kitchen. Residents do not have direct access to the machine in its new location. 1f) All hot beverages are served out of the kitchen in hot beverage air pots. Residents who are physically able to dispense beverages from the air pots are able to do so, all other residents are assisted by staff. 2a) The bathroom vent in room #507 has been repaired. 2b) An end cover piece for the heat vent in the sun room has been ordered and will be installed. Until the new part is received the metal edge has been covered with tape to prevent exposure. 2c) The bathroom vent in room #504 has been repaired. 2d) An new vent cover has been ordered for the bathroom heat vent in room #602 and will be installed. Until the new part is received the metal edge has been covered with tape to prevent exposure.	

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F 371	Continued From page 19 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure sanitary conditions in 2 of 2 facility kitchens. The findings were: Observation on 1/6/14 at 2:50 PM showed the following concerns in the main kitchen: a. The hand washing sink in the main kitchen was being used to store dirty dishes. Interview with cook #1 at that time verified the dirty dishes should not be placed there. b. Two wet wiping cloths were located on preparation counters in the kitchen. Further observation revealed there was no bucket or sink with a prepared sanitizer solution to keep the wet cloths in. According to Food Code 2013, U.S. Public Health Service: 3-304.14. "...(B) Cloths in-use for wiping counters and other equipment surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under § 4-501.114;" c. The reach-in refrigerator unit containing condiments had what appeared to be spilled salad dressing in the bottom of the unit along with various bits of dried food and debris. d. The electric meat slicer was covered and stored; however, upon inspection the counter	F 371	**Corrective Action:** 1. On 1/6 the hand washing sink in the main kitchen was being used to store dirty dishes 1a) As of 1/31 no dirty dishes are to be stored in any hand washing sink. Dirty dishes are to be placed in approved receptacles and taken to dish washing area after use. 2. Two wet wiping cloths were placed on preparation counters in the kitchen. Further observation revealed there was no bucket or sink with prepared sanitizer solution to keep wet cloths in. 2a) As of 1/31, all cloths are to be stored in buckets marked for approved sanitizer solution only. No cloths are to be stored on preparation tables. 3) The reach in refrigerator unit containing condiments had what appeared to be spoiled salad dressing in the bottom of the unit along with various bits of dried food and debris. 3a) As of 1/31 the ~~reach-in~~ (cleaned FB) refrigerators have been thoroughly and all debris and spills have been cleaned. (- removed FB) 3b) All reach- in coolers have been added to a regular cleaning schedule that is followed up by general manager or designee to ensure cleanliness is sustained.	

both words added per phone request of 2/14/14 @ 3:30 pm 02/13/14 FB

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F 371	Continued From page 20 area under the slicer was soiled with dried pieces of food. e. Two blender units were stored on the counter for use. The food pitchers of these units were noted to have a whitish film covering the inside of the pitchers which was able to be scraped off with a fingernail. Interview with the dietary manager on 1/8/14 at 11:20 AM verified the film was due to hard water and it needed to be cleaned with the appropriate cleaner. f. The kitchen floors and wheels of the movable racks and carts throughout the kitchen were soiled with a build-up of grease and grime. Interview with the dietary manager and the regional dietary supervisor on 1/8/14 at 11:25 AM revealed they were aware the kitchen was in need of deep cleaning, and a schedule was being prepared. Observation on 1/6/14 at 3:15 PM showed the following concerns located in the secure unit kitchenette: a. The interiors of the refrigerator and freezer were in need of cleaning. b. The refrigerator contained items that were not dated/labeled including a clear plastic container with pasteurized shell eggs, a bowl of what appeared to be pudding, a large beverage pitcher filled with what appeared to be salad dressing. c. An electric griddle was located on the counter that had not been cleaned from previous use. According to Food Code 2013, U.S. Public Health Service 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. "...(C) NonFOOD-CONTACT	F 371	4) The electric meat slicer was covered and stored, however, upon inspection the counter area under the slicer was soiled with dried pieces of food. 4a) As of 1/31 the electric slicer and surrounding counter tops have been thoroughly cleaned and all food debris removed. 4b) The Electric meat slicer and surrounding areas have been added to a regular cleaning schedule that is followed up by general manager or designee to ensure cleanliness is sustained. 5) Two blender units were stored on the counter for use. The food pitchers of these units were noted to have a whitish film covering the inside of the pitchers which was able to be scraped with a fingernail. 5a) All hard water affected equipment has been properly cleaned with appropriate chemicals and sanitized for use. 5b) The contracted dish machine service company has been contacted for service of water softener to acceptable levels. 6) The kitchen floors and wheels of moveable racks and carts throughout the kitchen were soiled with a buildup of grease and grime.	

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F 371	Continued From page 21 SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris." F 441 483.65 INFECTION CONTROL, PREVENT SS=E SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (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	F 371 F 441	**F441** It is the practice of the facility to establish an infection control program designed to provide safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. **Corrective Action:** Resident #6 was removed from contact isolation on 1/8/14 by SDC after confirmation of negative lab results. Resident #20's infection has resolved and resident was removed from isolation on 1/7/14. Resident #63's infection has resolved and resident #63 was removed from isolation on 1/17/14. The wall mounted hand sanitizer gel dispensers will be cleaned and inspected by the housekeeping supervisor following manufacturer recommendations. If the hand sanitizer gel dispenser continues to not function properly after cleaning it will be replaced. A care plan was written for resident #6 address infection. The care plan included condition requiring precautions, type of infection prevention precautions and criteria for ending precautions. A care plan was written for resident #20 to address infection. The care plan	

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F 441	Continued From page 22 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies and procedures, the facility failed to ensure staff followed procedures for transmission-based precautions for 2 of 3 posted resident rooms (#6 and #63). The facility further failed to clean and maintain 17 of 22 hand hygiene dispensers and failed to update care plans for 2 of 3 residents (#6, #20) with epidemiologically significant infections. The findings were: 1. Observation while touring the facility on 1/6/14 beginning 1:40 PM revealed 3 rooms posted with "contact precautions" signage and PPE carts positioned adjacent to the doors. These residents (#6, #20, and #63) were placed on transmission-based precautions to reduce the risk of further exposure to other residents, staff, and visitors. Continued observation of staff entering and leaving these posted resident rooms revealed the following deficiencies: a. On 1/7/14 at 10:35 AM, CNA #3 was observed to enter resident #63's room; a PPE cart and "contact precautions" were at the doorway leading into the resident's room. The CNA did not use any PPE when entering the room or assisting the resident, neither did she perform any hand hygiene before, during, or after assisting the resident. When asked at that time the CNA stated she did not think PPE was necessary unless she was actually providing care to the resident. Review of the facility policy for	F 441	included condition requiring precautions, type of infection prevention precautions and criteria for ending precautions. **Identification of Others:** The Staff Development Coordinator will review any residents on isolation precautions to determine if appropriate interventions are in place and if precautions are still necessary. Corrective actions will be taken as needed. An audit of care plans of residents who have infections will completed by Director of Nursing or designee to determine if the care plan includes condition requiring infection, type of infection prevention precautions and criteria for discontinuing precautions. Care plans will be updated as needed based on audit findings. The housekeeping supervisor will inspect wall mounted hand gel dispensers for cleanliness and proper functions. Corrective actions will be taken as needed. **Systemic Changes:** The Staff Development Coordinator will educate staff on infection prevention precautions, including when to use PPE, when to wash hands, gloving, resident hand washing and knowing the reason that someone is on infection prevention precautions.	

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F 441	Continued From page 23 "contact precautions" as printed on the signage posted at the resident's door, all staff entering the room must use disposable gloves and perform hand hygiene. Review of resident #63's medical record on 1/7/14 at 11:05 AM showed the resident was placed on transmission-based precautions following the detection of extended-spectrum beta lactamase producing Escherichia coli isolated from a urine sample. b. On 1/7/14 at 12:25 PM, CNA #4 was observed to enter resident #6's room and adjust the resident's clothing, assist him/her into a wheelchair, handle high-touch environmental surfaces, and hold the resident's hand prior to transporting the resident from the room. There was a PPE cart and "contact precautions" signage at the residents door. In addition, the posted precautions includes a statement that the resident's hands must be washed each time s/he left the room. During the observation, the CNA did not use any PPE, did not wash her hands, and did not assist the resident to wash his/her hands before leaving the room to have lunch in the dining room. The CNA stated in interview on 1/7/14 at 1:15 PM that she was not aware that PPE and hand hygiene were necessary unless she actually performed direct cares for the resident. She further stated she was not sure why the resident was under contact precautions. Review of the resident's medical record on 1/7/14 at 2:05 PM revealed precautions were implemented following a diagnosis of Clostridium difficile infection. c. The IP stated in interview on 1/8/14 at 2:40 PM that all staff were trained on infection control precautions, the use of PPE, and hand hygiene practices. She acknowledged that, at a minimum, disposable gloves and hand hygiene were required of staff working with residents #6 and	F 441	The housekeeping supervisor will establish a schedule for cleaning, filling and checking hand sanitizer gel dispensers for proper function. The housekeeping supervisor will educate housekeeping staff on the schedule for cleaning, filling and checking hand sanitizer gel dispensers. The Director of Nursing or designee will educate nurses on developing care plans for those with infections, including condition requiring infection precautions, type of infection precautions and criteria for discontinuing precautions. The Staff Development Coordinator or designee will round on residents with infection precautions 3 times per week to monitor infection precautions, staff performance, and knowledge of reason for precautions, documentation, care plan and review of laboratory work and determine continued need for isolation. If isolation precautions are no longer needed precautions will be removed and care plan amended to reflect the changes. The 24 hour report, new telephone orders and new physician orders and therapy communication tools will be reviewed 3 times per week at morning interdisciplinary team meeting by Director of Nursing or designee. Care plans will checked after meeting to	

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F 441	Continued From page 24 #63. She further stated hand hygiene prior to leaving the room was a requirement for resident #63. 2. Wall-mounted hand hygiene gel dispensers were observed on the 100, 200, 300, 400, and 500 hallways when touring the facility on 1/6/14 and 1/7/14. The following problems were discovered with the functioning of hand hygiene gel dispensers: a. Random inspection of dispensers on all 5 hallways revealed 8 of the devices that malfunctioned in use, either failed to dispense sufficient alcohol-base hand gel to sanitize hands or dispensed a stream of gel at an acute angle that missed the users hands. Closer inspection revealed 17 of 22 product dispensers had 1/8 to 1/2 inch accumulation of dried sanitizer gel under the pump handle, dispenser nozzle, and/or plastic housing that interfered with proper operation. b. The IP confirmed in interview on 1/6/14 at 4:05 PM that the hand hygiene dispensers needed to be cleaned of the dried residual product. She directed the job to the housekeeping supervisor on 1/6/14 at 4:15 PM. The supervisor was observed throughout the day on 1/7/14 wiping the dispensers with paper towels to remove old product. Repeat observation on 1/7/14 at 3:55 PM and again at 5:10 PM revealed that the process of wiping dispensers with paper towels lead to further problems of dispensing nozzles being plugged or blocked by dried gel product, with 6 dispensers failing to function correctly. In addition, an unidentified visitor was observed using a hand hygiene dispenser on 1/7/14 at 4:40 PM; the visitor pumped the dispenser handle 8 times without any sanitizer gel being dispensed. The visitor left the facility after attempting to use the dispenser; about 3 minutes	F 441	determine if new or changes in infections are addressed. **Monitoring:** The Staff Development Coordinator or designee will complete random audit 3 times weekly for 90 days of residents on infection control precautions. The audit will include visual observation of staff performance in care of those on precautions, staff knowledge of reason for precautions, care plans for infections. Corrective actions will be taken as needed for any identified concerns. The housekeeping supervisor will complete a random audit of 10 hand gel dispensers 3 times per week or cleanliness, fullness and proper function. Corrective actions will be taken as needed for any concerns identified. The Staff Development Coordinator or designee will track and trend the results of the infection control audits and hand gel dispensers monthly and report findings to the QAPI committee monthly. The QAPI committee will evaluate effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure compliance monthly for three months and then reassess the need for continued monitoring based on compliance.	2/19/14 2/14/2014

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F 441	Continued From page 25 later a large mass of sanitizer gel dropped from the dispenser to the floor. c. Interview with the housekeeping supervisor on 1/8/14 at 2:26 PM revealed he was unaware his method of wiping dispenser with paper towels was ineffective in returning the devices to proper function. He had not checked the dispensers after wiping them off. d. Review of manufacturer's instructions for the hand hygiene dispensers on 1/7/14 at 8:35 PM confirmed that the pump handle, nozzle, and lower housing assembly must be free of accumulated waste material to ensure the device operated correctly. 3. Observation while touring the facility on 1/6/14 beginning at 1:45 PM revealed 3 resident rooms posted with transmission-based precautions. Review of resident care plans for these residents on 1/7/14 beginning at 10:50 AM revealed 2 residents (#6 and #20) lacked any information in their care plan to indicate infection prevention precautions were in place, conditions requiring precautions, criteria for ending infection prevention precautions, or any special conditions or goals for the residents impacted by the precautions. The IP confirmed in interview on 1/8/14 at 3:20 PM that the 2 residents cited lacked care plan updates to reflect the current infection control precautions.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		

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F 465	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a clean and sanitary environment in 1 of 3 utility rooms inspected. The findings were: Observation while touring the facility on 1/6/14 at 2:05 PM revealed evidence of water damage in 1 (100 hallway, across from room 104) of 3 utility rooms inspected on tour. The floor of the room adjacent to the plumbed side of the room was damp and the lower section of sheetrock showed signs of water stains; the baseboard and backing material was deteriorated and came apart in small pieces when the surveyor checked the integrity of the material. A black, powdery substance was dispersed over an area approximately 3 feet long and extending 4 to 12 inches above the deteriorated baseboard; when inspected more closely, the black material appear to be mold. While inspecting the room, an unidentified staff member entered the room and put a trash bag into a larger trash receptacle stored in the utility room. Interview with RN #1 on 1/6/14 at 2:15 PM confirmed the utility room had water damage and acknowledged that staff used the room to store trash pending final disposal. The RN further acknowledged the room appeared to have water damage.	F 465	**F465** It is the practice of the facility to provide a safe, functional, sanitary and comfortable environment for resident, staff and the public. **Corrective Action:** The identified utility room was immediately taken out of service. The room was thoroughly cleaned and damaged sheet rock was removed and replaced. On 1/30/2014, the Administrator conducted an in-service with staff concerning reporting of water damage issues to the Maintenance Department immediately. **Identification of Others:** The Maintenance Supervisor or designee conducted an audit of the facility storage and utility rooms to identify any other signs of water damage. **Systematic Changes:** The Maintenance Supervisor or designee will conduct quarterly audits of the facility for water damage according to the TELS schedule.	
F 467 SS=D	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical	F 467	Staff members will use a heat ticket system to report any water damage to the Maintenance Department.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	536024	A. BUILDING _____ B. WING _____	C 01/09/2014

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 465	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a clean and sanitary environment in 1 of 3 utility rooms inspected. The findings were: Observation while touring the facility on 1/6/14 at 2:05 PM revealed evidence of water damage in 1 (100 hallway, across from room 104) of 3 utility rooms inspected on tour. The floor of the room adjacent to the plumbed side of the room was damp and the lower section of sheetrock showed signs of water stains; the baseboard and backing material was deteriorated and came apart in small pieces when the surveyor checked the integrity of the material. A black, powdery substance was dispersed over an area approximately 3 feet long and extending 4 to 12 inches above the deteriorated baseboard; when inspected more closely, the black material appear to be mold. While inspecting the room, an unidentified staff member entered the room and put a trash bag into a larger trash receptacle stored in the utility room. Interview with RN #1 on 1/6/14 at 2:15 PM confirmed the utility room had water damage and acknowledged that staff used the room to store trash pending final disposal. The RN further acknowledged the room appeared to have water damage.	F 465	**Monitoring:** Maintenance Supervisor will report the results of the water damage audit to Safety Committee according to the TELS schedule. 2/14/14 BB 2/14/2014	
F 467 SS=D	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical	F 467		

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F 467	Continued From page 27 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 resident bathrooms for 2 of 6 hallways (200 hallway, 300 hallway). The findings were: Periodic observations from 1/6/14 at 2:25 PM through 1/8/14 at 2:20 PM revealed the facility had a noticeable odor of stale urine in the 200 and 300 hallways. On 1/6/14 at 4:50 PM the bathroom ceiling exhaust fans were checked for ventilation adequacy in resident rooms #305, #306, and #314. In each room, there was no noticeable air movement. During the survey period from 1/6/14 at 4:50 PM through 1/8/14 at 2:20 PM, all resident bathroom exhaust fans were checked for adequacy in the 200 and 300 hallways, and there was no noticeable air movement. Both hallways continued to have the smell of stale urine throughout the survey. Interview with the maintenance director on 1/8/14 at 2:20 PM confirmed the exhaust fans were not working. He stated he planned to address this issue throughout the facility. However, the facility failed to have a plan with a specific timeframe to address this issue.	F 467	**F467** It is the practice of the facility to have adequate outside ventilation. **Corrective Action:** Upon inspection of the exhaust vent fan in resident room #305, the Maintenance Supervisor determined that the vent fan needed to be replaced. A replacement fan was ordered and will be installed when it arrives. The exhaust vent filters in resident rooms #306 and #314 were replaced. All other exhaust vents on halls 2 and 3 had the filters replace to improve air movement. **Identification of Others:** The Maintenance Supervisor or Designee conducted an audit of all the bathroom vent fans in the facility on 1/31/2014. **Systematic Changes:** The Maintenance Supervisor or designee will conduct quarterly audits of the facility exhaust vent fans according to the TELS schedule. Staff members will use a heat ticket system to report any malfunction of bathroom vent fans to the Maintenance Department.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;	F 514		

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F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;	F 514		

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F 514	Continued From page 28 accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure the electronic resident records were accurate related to bathing for 3 of 17 sample residents (#13, #19, #28) and related to bowel monitoring for 1 of 17 sample residents (#29). The findings were: In regard to bathing: 1. Review of the October, November and December 2013 to January 8, 2014 bathing/shower report for residents #28 showed weeks where baths/showers were not documented. The monitoring record showed the resident was not bathed for 14 days from 11/26/13 to 12/10/13, eleven days from 12/10/13 to 12/21/13, and eleven days from 12/21/13 to 1/1/14. Review of the 7/29/13 care plan for ADLs failed to show a plan for bathing or showers. 2. Review of the November and December 2013 shower report for resident #13 showed the resident went without a shower or bath for 11 days from 11/21/13 to 12/2/13, and for 21 days from 12/2/13 to 12/24/13.	F 514	**F 514** It is the practice of the facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized. **Corrective Action:** The Director of Nursing or designee will interview resident #13 and C.N.A. to determine last ~~bowel movement~~ shower. Care Tracker documentation will be reviewed for accurate documentation. ~~If there has been no bowel movement in past 3 days interventions will be initiated~~. The Director of Nursing or designee will interview resident #19 and C.N.A. to determine last ~~bowel movement~~ shower. Care Tracker documentation will be reviewed for accurate documentation. ~~If there has been no bowel movement in past 3 days interventions will be initiated~~. The Director of Nursing or designee will interview resident #28 and C.N.A. to determine last ~~bowel movement.~~ shower Care Tracker documentation will be reviewed for accurate documentation. ~~If there has been no bowel movement in past 3 days interventions will be initiated.~~	

all changes made via phone request of NHA on 2/13/14 at 3:30 pm

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F 514	Continued From page 29 3. Review of October, November and December 2013 bathing/shower report showed resident #19 went without a bath or shower 14 days from 11/2/13 to 11/16/13, and for 10 days from 12/14/13 to 12/25/13. 4. Interview with CNAs #1 and #2 on 1/9/14 at 10:25 AM verified the residents were provided baths at least once weekly. The CNAs stated the computer program (Care Tracker) which was used to input the information had a "glitch" and sometimes the baths/showers did not show up on the monitoring reports. The CNAs verified there was no other source of documentation to show when residents were bathed/showered. In regard to bowel monitoring: 1. Review of the 12/1/13 quarterly MDS for resident #29 showed the resident required limited assistance with toileting, was continent of bowel and had severe cognitive impairment. Review of 11/7/13 care plan showed interventions included observe for bowel pattern to ensure adequate bowel elimination to address problem of constipation. 2. During an interview on 1/8/14 at 8:30 AM, RN #3 revealed the system for monitoring whether or not the resident had a bowel movement within 3 days consisted of daily documentation in the "Care Tracker" computer database. Review of the documentation in the "Care Tracker" computer database showed the resident did not have a bowel movement during the following days: 10/20/13 to 10/23/13 (4 days), 10/29/13 to 11/1/13 (4 days), 11/3/13 to 11/12/13 (10 days), 11/15/13 to 11/24/13 (9 days), 11/26/13 to 12/8/13 (12 days), 12/10/13 to 12/29/13 (19 days), and	F 514	The Director of Nursing or designee will interview resident #29 and C.N.A. to determine date of last ~~bath~~ bowel movement. Care Tracker documentation will be reviewed for accurate documentation. Corrective action will be taken as needed. **Identification of Others:** The Director of Nursing or designee will review bowel elimination documentation for the past month to identify any residents with no documentation of bowel movement for 4 or more days. For those identified bowel regimen will be reviewed and changes made as needed. The Director of Nursing or designee will review bath documentation for the past month to identify any residents with no documentation of bathing twice per week. For those identified bathing choices and plan of care for baths will be reviewed and updated as needed. **Systematic Changes:** The Staff Development Coordinator or designee will educate licensed nurses on bowel management including bowel movement documentation and daily review, bowel protocol, physical assessment and follow up for anyone who has not had a bowel movement in past 3 days.	

Chg per request of NHA via phone 2/3/14 - 3:30 pm LB

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F 514	Continued From page 30 12/31/13 to 1/6/14 (6 days). 3. Interview with the DON and RN #1 on 1/9/14 at 10:15 AM revealed a nursing assessment confirmed the resident was not currently having problems with constipation. However, they further stated the computer database had malfunctioned and needed to be repaired to correct the errors in the current bowel monitoring system. Interview with the DON on 1/9/14 at 10:40 AM verified the computer system may have some problems. She stated the CNAs have reported information was sometimes missing from the reports although it was entered into the system. The DON then stated this computer issue was not yet in the process of being fixed or evaluated.	F 514	The Director of Nursing will review the audits of bowel management and bathing documentation for trends and report monthly to the QAPI Committee. The QAPI Committee will evaluate the effectiveness of the plan based on trends identified and implement additional interventions as needed to ensure continued compliance, monthly x3 months. The QAPI Committee will then determine if any further action is required.	2/14/2014 2/19/14 JB
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the	F 520	**F520** It is the practice of the facility to maintain a quality assessment and assurance committee. **Corrective Action:** An Ad Hoc Performance Improvement Plan was developed by the facility Interdisciplinary Team on 1/9/2014 to address identified Infection Control concerns. The Ad Hoc Summary was adopted by the QAPI Committee in the regularly scheduled meeting on 1/20/2014. **Identification of Others:** Current Performance Improvement Plans were reviewed by the QAPI committee and updated as necessary. Additional Performance Improvement Plans were identified by the committee and implemented during the 1/20/2014 meeting.	

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F 520	Continued From page 31 compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview, medical record review, and review of facility documents, the facility failed to ensure the quality assurance (QA) and performance improvement (PI) program was effective in identifying and resolving problems related to infection control. The findings were: Review of findings from the facility's last four surveys; dated 10/18/12, September 2011, November 2010, and October 2009, revealed the facility was repeatedly cited for their failure to implement an effective infection control program. Survey findings from this current survey further established the facility's long-standing non-compliance with infection control requirements. Interview with the administrator, the DON, and IP on 1/9/14 at 9 AM verified the QAPI process was not sufficient in this area, and additional data collection and analysis was needed to improve the infection control practices in the facility. Refer to Federal citation F441 for details related to infection control deficiencies during the current survey.	F 520	**Systematic Changes:** The QAPI committee members will be educated on the QAPI process including identification and resolution of problems.. Identified trends requiring a Performance Improvement Plan will be addressed monthly by the Interdisciplinary Team in the QAPI meeting. Ad Hoc Performance Improvement Plans for items requiring more immediate attention will be implemented in Morning Meeting as needed. **Monitoring:** The Performance Improvement Plan for Infection Control will be reviewed each month in QAPI to ensure positive outcomes. The Interdisciplinary Team will review the plan and make adjustments as necessary to monitor positive infection control outcomes. Corrective actions will be taken as needed for any identified concerns. 2/19/14 JB 2/14/2014	

JB