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

PRINTED: 02/09/2015
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 01/06/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted at Poplar Living Center from 12/30/14 to 1/6/15. The survey was prompted by complaint intakes WY00001961 and WY00001967. The following common abbreviations are used throughout this document: ADL - Activities of Daily Living CNA- Certified Nurse Aide DON- Director of Nursing MAR - Medication Administration Record MDS- Minimum Data Set RN- Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000	Preparation and/or execution of the response and plan of correction do not constitute admission of 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 the provisions of federal and state law require it.	
F 309 SS=E	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, resident and staff interview, and policy and procedure review, the facility failed to monitor the bowel elimination	F 309	F-309 Corrective Action	~~2/16/15~~ 2/23/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE ~~01/30/2015~~ 2/13/15

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.

2/19/15 This POC accepted between Tony Janusz - Administrator and Tony Maddon, Surveyor with a POC of 2/23/15 for all tags. 2/19/15

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F 309	Continued From page 1 pattern for 5 of 6 sample residents (#1, #3, #4, #5, #6) to prevent constipation. The findings were: 1. Review of the 11/29/14 quarterly MDS assessment showed resident #6 had moderate cognitive impairment and required extensive assistance with toileting and incontinence care. In an interview on 12/31/14 at 11 AM, the resident stated "constipation makes me miserable," and during the month of December 2014 s/he "kept telling them and telling them," s/he needed something for constipation but staff was slow to respond. Interview with RN #1 on 12/31/14 at 11:50 AM revealed staff were to monitor the resident's bowel patterns and administer "as needed" laxatives if the resident did not have a bowel movement for three days. Review of the bowel elimination records showed the resident did not have a bowel movement from 12/2/14 to 12/7/14 (5 days) and from 12/8/14 to 12/14/14 (6 days). Review of the corresponding December 2014 MARs showed the facility administered the "as needed" laxative on 12/19/14, 12/20/14, 12/21/14, and 12/30/14 during that month. 2. Review of the bowel elimination documentation showed resident #1 did not have a bowel movement from 12/6/14 until 12/16/14 (10 days). Review of the corresponding December 2014 MARs showed the facility bowel protocol was not initiated. 3. Review of the bowel elimination documentation showed resident #3 did not have a bowel movement from 12/10/14 until 12/15/14 (5 days). Review of the corresponding December 2014 MARs showed the facility bowel protocol was not initiated.	F 309	Resident's #1 and #5 have been discharged from the facility. Resident's #3, #4, and #6 have had regular bowel movements as evidenced by our "no bowel movement for 9 shifts" report and, if necessary, have been provided a PRN intervention which was monitored for effectiveness. Identification of Others The Director of Nursing and/or Designee will conduct audits of the Care Tracker database to determine the frequency in which residents have experienced bowel elimination. Residents found to have not experienced bowel elimination as evidenced by the facility's "no bowel movement for 9 shifts" report, will receive an appropriate PRN intervention. Residents receiving a PRN intervention will have their bowl condition monitored to validate the PRN intervention was effective. Systemic Changes The Director of Nursing and/or Designee will provide education to nursing staff addressing the inputting and monitoring of the Care Tracker database to determine the frequency of residents bowel elimination including interventions and outcomes.	

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F 309	Continued From page 2 4. Review of the bowel elimination documentation showed resident #4 did not have a bowel movement from 12/8/14 until 12/13/14 (5 days) and from 12/22/14 to 12/28/14 (6 days). Review of the corresponding December 2014 MARs showed the facility bowel protocol was not initiated during either of these time frames. 5. Review of the bowel elimination documentation showed resident #5 did not have a bowel movement from 12/4/14 until 12/13/14 (9 days), from 12/16/14 to 12/24/14 (8 days) and from 12/25/14 to 12/29/14 (4 days). Review of the care plan updated on 12/30/14 showed care plan goals included having adequate bowel elimination every three days. Review of the corresponding December 2014 MARs showed an "as needed" laxative was administered one time during the month, on 12/24/14. 6. Interview with the administrator and DON on 12/31/14 at 6:40 PM revealed there were new facility staff who were not currently proficient at documenting on the electronic bowel and bladder tracking system. According to the facility policy and procedure titled, "Bowel and Bladder Management" revised February 2010, under "Cognitive Impaired Residents" "...5. Steps for starting a bowel and bladder program are: a. Establish an elimination pattern, monitor ...II. Continent or Incontinent status: Bowel and Bladder Care Tracker Reports...will be reviewed by the Licensed Nurse to assist with evaluation of bowel and bladder status...f. Identify the plan for elimination management."	F 309	The Director of Nursing and/or Designee will conduct audits of the Care Tracker database for three (3) months to determine the frequency in which residents have experienced bowel elimination. Residents found to have not experienced bowel elimination as evidenced by the "no bowel movement for 9 shifts" report will receive an appropriate PRN intervention. Residents receiving the PRN intervention will have their bowel condition monitored to validate the intervention was effective. Monitoring The Director of Nursing and/or Designee will bring the results of the audits/observations to the monthly QAPI Committee for three (3) months for review and recommendations. Date of compliance is ~~February 16, 2015~~. 2/23/15	

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F 309	Continued From page 3	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, and resident and staff interview, the facility failed to ensure staff provided shower/bath assistance in a timely manner for 6 of 6 sample residents (#2, #3, #4, #5, #6, #12) who required assistance with ADLs. The findings were: 1. Review of the 11/24/14 quarterly MDS assessment showed resident #2 was totally dependent upon staff for showers/baths. Review of the December 2014 shower/bath records revealed the facility failed to ensure the resident received a shower/bath from 12/9/14 until 12/15/14 (7 days), from 12/16/14 until 12/22/14 (7 days), and from 12/23/14 until 12/29/14 (7 days). 2. Review of the medical record showed resident #3 was admitted to the facility on 3/19/09 with diagnoses which included non-Alzheimer's dementia. Review of the 11/14/14 quarterly MDS assessment showed resident #3 required extensive assistance from staff for	F 312	F-312 Corrective Action Resident #5 has been discharged from the facility. Resident's #2, #3, #4, #6, and #12 have received bathing services, established a bathing frequency preference, and will be provided their bathing services in accordance with the established schedule. Identification of Others. The Director of Nursing and/or Designee will conduct audits of the bathing schedule to validate residents were provided bathing services in accordance with their established schedule.	~~2/10/15~~ 2/23/15

2/19/15

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F 312	Continued From page 4 showers/baths. Review of the December 2014 shower/bath records revealed the facility failed to ensure the resident received a shower/bath from 12/4/14 until 12/20/14 (16 days). Review of the care plan showed no preferences were identified regarding shower/bath frequency until after the survey started, on 12/31/14 (69 months and 12 days after admission). The "late entry 12/31/14" stated, "Res [resident] preferred to bath[e] one day a week." 3. Review of the medical record showed resident #4 was admitted to the facility on 12/5/13 with diagnoses which included Alzheimer's Disease. Review of the 12/8/14 quarterly MDS assessment showed resident #4 was totally dependent on staff for showers/baths. Review of the December 2014 shower/bath records revealed the resident received 6 shower/baths during the month of December 2014. Further review of the records showed no documented refusals. 4. Review of the medical record showed resident #5 was admitted to the facility on 12/3/14 with diagnoses which included dementia and stroke. Review of the 12/30/14 care plan revealed the resident required total care with bathing. Review of the December 2014 shower/bath records revealed the facility failed to ensure the resident received shower/baths from 12/17/14 to 12/25/14 (8 days). Further review showed no documented refusals. 5. Review of the medical record showed resident #6 had diagnoses which included non-Alzheimer's dementia. Review of the 11/29/14 quarterly MDS assessment showed the resident required extensive assistance with all ADLs, but bathing did not occur during this	F 312	Resident's identified not receiving a bath in accordance with the established bathing schedule will be offered the opportunity to bathe. Systemic Changes The Director of Nursing and/or Designee will provide education to nursing staff addressing the expectation that all residents receive bathing services in accordance with the established bathing schedule. The Director of Nursing and/or Designee will provide education to licensed nurses addressing the monitoring of the bathing charting in the Care Tracker database, comparing it to the established bathing schedule, and validating resident's received bathing services as scheduled. The Director of Nursing and/or Designee will provide education to nursing staff addressing the expectation that residents not receiving their bathing services in accordance with the established bathing schedule will be offered bathing services. The Director of Nursing and/or Designee will conduct weekly audits for three (3) months to validate residents are being provided bathing in accordance with their established bathing schedule. Monitoring The Director of Nursing and/or Designee will bring the results of the	

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F 312	Continued From page 5 assessment time period. Review of the December 2014 shower/bath records revealed the facility failed to ensure the resident received a shower/bath from 12/2/14 until 12/10/14 (8 days) and from 12/10/14 to 12/20/14 (10 days). Interview with the resident on 12/31/14 at 11 AM revealed sometimes s/he did not receive showers/baths for over a week due to lack of staff. 6. Review of the 9/10/14 quarterly MDS showed resident #12 required physical assistance of one for bathing. Review of the 11/5/14 quarterly MDS assessment showed the resident required physical assistance of two staff for bathing. Interview with the resident on 12/31/14 at 9:40 AM revealed the facility failed to ensure s/he had a bath or shower for the last week, and this was not unusual. The resident stated s/he told CNAs this was not acceptable, but was told they were doing the best they could. Interview with the administrator on 12/31/14 at 6:40 PM confirmed the facility had identified a staff shortage that was ongoing. Interview with the DON at that time revealed she considered 2 showers/baths per week to be acceptable unless specified otherwise.	F 312	audits/observations to the monthly QAPI Committee for three (3) months for review and recommendations. Date of compliance is ~~February~~ 16, 2015 2/23/15 RD	
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	F 323		~~2/18/15~~ 2/23/15 RD

2/19/15 RD

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F 323	Continued From page 6 adequate supervision and assistance devices to prevent accidents.	F 323		

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interview, the facility failed to ensure effective interventions and/or post-fall assessments were implemented to prevent falls for 2 of 3 sample residents (#5, #8) identified at risk for falls. The lack of effective interventions resulted in harm for resident #5. The findings were:

1. Review of the medical record showed resident #5 was admitted to the facility on 12/3/14 with diagnoses which included encephalopathy, acute kidney failure, history of TIA/CVA (transient ischemic attack/stroke) without residual, hip replacement (September 2014), and urinary incontinence. Review of the nursing admission notes dated 12/3/14 and timed at 5 PM showed the resident was "very unsteady on feet" and had poor balance. In addition, it was noted the resident required extensive assistance with transfers and locomotion. Review of the 7 PM to 7 AM shift nursing notes dated 12/3/14 showed the resident was confused, had an unsteady gait, wandered about, and kept removing the safety alarm that was placed for safety. It was also noted the resident was weak and required extensive assistance with mobility and transfers. Review of the next nursing notes dated 12/4/14 and timed at 5 PM showed the resident was alert but restless, was incontinent, had an unsteady gait and was weak. The nursing notes written on 12/5/14 for the 7 PM to 7 AM shift showed the

F-323

Corrective Action

Resident's #5 and #8 have been discharged from the facility.

Identification of Others

The Director of Nursing and/or Designee will conduct a facility-wide audit of residents to validate the following:

a. The completions of falls risk evaluation reflecting a falls risk score;

b. The establishment of appropriate interventions in accordance with the resident's fall risk;

c. The resident's care plan reflects the appropriate interventions;

d. Communication to direct care staff addressing the resident's falls risk and interventions; and

e. The implemented interventions are effective.

f. A post-fall evaluation will be

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F 323	Continued From page 7 resident was bed/chair bound, weak, and required total assistance with cares. Review of the nursing notes written at 5 PM on 12/6/14 revealed physical therapy (PT) had reported the resident was having trouble bearing weight on the left leg that morning and s/he complained of pain. Interview with the DON on 1/16/15 at 2:10 PM revealed the physician was faxed this information at noon on 12/6/14. Further review of the nursing notes showed PT recommended using the sit-to-stand lift to assist with transfers with 2 persons. Interview with the DON on 1/16/15 at 2:10 PM verified when the physician was faxed about the fall he was asked to approve the recommendation for sit-to-stand lift and did so at that time. Review of the SBAR (Situation Background Assessment/Appearance/ Request) communication form and progress note dated 12/6/14 and timed at 5 PM showed the resident was having difficulty bearing weight on the left leg and complained of pain in the left hip. Continued review of the SBAR showed the resident was unsafe to bear weight on the left leg. Normally the resident was able to stand with the assist of one and a gait belt. Review of the 12/6/14 SBAR timed at 6:30 PM showed the resident had an unwitnessed fall. The resident was found in the dining room lying on his/her left side. The report showed the resident had blood on the forehead and left eye lid. The resident was transported to the emergency room for evaluation. The following concerns with fall prevention were identified: a. Review of the initial care plan completed on 12/4/14 showed the resident had a history of falls, decreased safety awareness, and wandering behaviors. The only intervention recommended on the initial care plan was to place a "wander guard, or other electronic safety devices as deemed necessary by assessment."	F 323	completed after every resident fall. Systemic Changes The Director of Nursing and/or Designee will provide education to licensed nurses addressing the falls management program. The Director of Nursing and/or Designee will review post-fall investigations, evaluations, and assessments at the next daily IDT meeting. The Director of Nursing and/or Designee will conduct weekly audits for three (3) months of all resident falls to validate the facility's falls management program is effective. Monitoring The Director of Nursing and/or Designee will bring the results of the audits/observations to the monthly QAPI Committee for three (3) months for review and recommendations. Date of compliance is ~~February~~ 16, 2015 2/23/15	

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F 323	Continued From page 8 This care plan was not specific or individualized for the resident. The staff placed an alarm on the resident. However, it was noted in the 12/3/14 nursing notes timed from 7 PM to 7 AM the resident removed the alarm which rendered this intervention ineffective. b. The resident was transported to the emergency room on 12/6/14 after the fall. Review of the history and physical performed on 12/6/14 showed x-ray of the left hip revealed dislocation of the left acetabular component without fracture. The dislocation was reduced in the emergency room. Upon re-admission to the facility on 12/8/14 (2 day hospital stay) the resident required a left knee and thigh brace according to the nursing note dated 12/8/14 and timed at 2 PM. Review of the fall risk evaluation performed on 12/8/14 showed the resident scored 21; a score of 10 or greater indicates high fall risk. Review of the transfer evaluation performed on 12/8/14 showed the resident required the use of a mechanical lift for transfers. Review of the medical record showed the care plan after the resident's re-admission was completed on 12/30/14, 22 days after re-admission and this care plan did not note the use of a brace or the sit-to-stand lift with assistance of two staff. c. According to the physician's telephone order on 12/12/14 timed at 4:45 AM, the resident had another fall with a head injury and required transport to the emergency room. Review of the emergency room notes verified the resident was seen for an evaluation of a fall on 12/12/14. Review of the nursing notes for 12/12/14 showed no documentation of the fall. 2. Medical record review showed resident #8 was re-admitted to the facility on 12/3/14 at 3 PM due	F 323		

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F 323	Continued From page 9 to general decline after having been discharged to his/her home on 9/5/14. Review of the 8/18/14 admission MDS assessment showed staff were required to transfer the resident from a sitting to a standing position, on and off of the toilet, and for surface to surface transfers. Review of the 8/28/14 and 12/6/14 fall risk evaluations showed the resident was at high risk for falls. Review of the 12/3/14 nursing notes showed the resident fell at 4 PM while being transferred to a recliner chair by a family member. Review of the entire medical record showed the facility failed to complete a review of the fall to determine if any additional measures were required to lower the risk for falls. Review of the care plan, last updated on 9/2/14, showed family members were not addressed as being appropriate for transferring the resident, and review of the entire medical record showed the facility failed to provide education to the resident's family members regarding safe transfers. 3. Interview with the administrator on 12/31/14 at 6:40 PM confirmed the facility had identified an ongoing staff shortage. He further acknowledged this staffing shortage had the potential to affect resident safety; which would include fall risk.	F 323		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and	F 353		~~2/16/15~~ 2/23/15

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 10 individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on shower/bath record review and resident and staff interview, the facility failed to consistently ensure 5 of 5 nursing units were sufficiently staffed to meet the needs of residents. The census was 101. The findings were: 1. Review of the shower/bath records showed the following residents failed to receive a shower/bath in a timely manner for the following time frames: a. Review of the December 2014 shower/bath records revealed the facility failed to ensure resident #2 received a shower/bath from 12/9/14 until 12/15/14 (7 days), from 12/16/14 until 12/22/14 (7 days), and from 12/23/14 until 12/29/14 (7 days). b. Review of the December 2014 shower/bath records revealed the facility failed to ensure resident #3 received a shower/bath from 12/4/14 until 12/20/14 (16 days).	F 353	F-353 Corrective Action Resident #5 has been discharged from the facility. Resident's #2, #3, #4, #6, and #12 have received bathing services, established a bathing frequency preference, and will be provided their bathing services in accordance with the established schedule. Resident #9 will be provided toileting assistance as needed and provided ice water on request and/or in accordance with he hydration program.	

2/19/15

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	535024	A. BUILDING _____ B. WING _____	C 01/06/2015

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F 353	Continued From page 11 c. Review of the December 2014 shower/bath records for resident #4 revealed the resident received 6 shower/baths during the month of December 2014. d. Review of the December 2014 shower/bath records for resident # 5 revealed the facility failed to ensure the resident received shower/baths from 12/17/14 to 12/25/14 (8 days). e. Review of the December 2014 shower/bath records for resident #6 revealed the facility failed to ensure the resident received a shower/bath from 12/2/14 until 12/10/14 (8 days) and from 12/10/14 to 12/20/14 (10 days). Interview with the resident on 12/31/14 at 11 AM revealed s/he sometimes did not receive showers/baths for over a week due to lack of staff. 2. The following resident interviews addressed the staffing shortage as follows: a. Interview with resident #9 on 12/31/14 at 9:10 AM revealed the facility failed to provide adequate staff to assist with ADLs in a timely manner, and some of the "new" staff were too inexperienced. S/he stated staff did not assist with toileting in a timely manner, and did not pass water and ice frequently enough. b. Interview with residents #10 and #11 on 12/31/14 at 9:30 AM revealed the facility needed additional staff, as call lights were not answered timely. c. Interview with resident #12 on 12/31/14 at 9:40 AM revealed the facility did not have enough staff, especially at night when the facility often had just 2 CNAs. S/he further stated the facility failed to ensure s/he had a bath or shower for the last week, and this was not unusual. The resident stated s/he told CNAs this was not acceptable, but was told they were doing the best they could.	F 353	Resident's #10 and #11 will have their call lights answered timely. Resident #13 will have their call light answered timely and provided ice water on request and/or in accordance with our hydration program. Identification of Others The Director of Nursing and/or Designee will staff the facility daily in a manner which allows for the nursing and related services to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and individual plans of care. The Director of Nursing and/or Designee will conduct audits of the Care Tracker data base to assess the frequency in which residents have experienced Activities of Daily Living services, ~~as compared to resident assessments and individual plans of care.~~ If ADL services were not documented corrective action will be taken as needed. If Care Tracker data reveals that residents did not receive the established Activities of Daily Living as compared to resident assessments and individual plans of care, the Director of Nursing and/or Designee will audit the nursing charting to determine its accuracy, correct any data if necessary, and/or validate the Activities of Daily Living services are subsequently provided. The Director of Nursing and/or Designee	

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F 353	Continued From page 12 d. Interview with resident #13 on 12/31/14 at 10:05 AM revealed the facility was short staffed, and it often took up to 30 minutes to answer call lights. The resident also stated staff only provided water and ice when requested due to inadequate numbers of staff. e. Interview with resident #6 on 12/31/14 at 11 AM revealed sometimes s/he lay 2 to 3 hours in urine soiled bed linen waiting for staff to respond to his/her request for incontinent care. 3. Interview with the administrator on 12/31/14 at 6:40 PM confirmed the facility had identified a staff shortage that was ongoing. He stated administrative staff attempted to help out. However, the facility failed to ensure administrative staff were assigned specific residents and/or specific tasks that addressed the ADL needs of individual residents. Interview with the DON at that same time revealed she considered 2 showers/baths per week to be acceptable unless specified otherwise. Direct observation rounds of residents will be completed by Director of Nursing or designee to determine if ADL needs were met in timely manner as evidenced by grooming, toileting, incontinence ~~[illegible]~~ being met ~~[illegible]~~. Corrective action will be taken as needed.	F 353	~~will educate the nursing staff regarding meeting the Activities of Daily Living needs of the residents based on resident assessments and individual plans of care.~~ ~~The Director of Nursing and/or Designee will provide education to nursing staff and validate the hydration program of providing ice and waver to residents is implemented and effective.~~ ~~The Director of Nursing an/or Designee will conduct random weekly audits to validate residents are receiving water and ice in accordance with hydration program.~~ ~~The Director of Nursing and/or Designee will provide education to nursing staff addressing the expectation of the response time to a resident's call light.~~ ~~The Director of Nursing and/or Designee will conducted random weekly audits of call lights to validate staff response times are appropriate and meet the needs of the residents.~~ Systemic Changes ~~Weekly Staff~~ The Director of Nursing and/or Designee will continue to explore internal and external recruitment and retention opportunities in order to staff the facility in a manner which allows for the nursing and related services to attain and maintain the highest practicable physical, mental and psychosocial well-being of each resident ~~as determined by resident assessments and individual plans of care.~~ → facilitate weekly staffing meeting to	

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F 353	Continued From page 13	F 353	The Director of Nursing and/or Designee will provide education to nursing staff addressing the expectation that residents receive bathing services in accordance with established bathing schedule. The Director of Nursing and/or Designee will provide education to licensed nursed addressing the monitoring of the bathing charting in the Care Tracker data base, comparing it to the established bathing schedule, and validating resident's received bathing services. The Director of Nursing and/or Designee will provide education to nursing staff addressing the expectation that residents not receiving their bathing services in accordance with the established bathing schedule will be offered bathing services. The Director of Nursing and/or Designee will conduct weekly audits for three (3) months to validate residents are being provided bathing in accordance with their established bathing schedule. The Director of Nursing and/or Designee will conduct random weekly audits of the Care Tracker data base for three (3) months to assess the frequency in which residents have experienced Activities of Daylily Living services ~~as compared to resident assessments and individual plans of care.~~ If Care Tracker data reveals that residents did not receive the established activities of	

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F 353	Continued From page 14	F 353	Daily Living as compared to ~~resident~~ assessments and individual plans of care, the Director of Nursing and/or Designee will audit the nursing charting to determine its accuracy, correct any data if necessary, and/or validate the Activities of Daily Living services are subsequently provided. The Director of Nursing and/or Designee will provide education to nursing staff and validate the hydration program of providing ice and water to residents is implemented and effective. The Director of Nursing and/or Designee will conduct random weekly audits for three (3) months to validate residents are receiving water and ice in accordance with the hydration program. The Director of Nursing and/or Designee will provide education to nursing staff addressing the expectation of the response time to a resident's call light. The Director of Nursing and/or Designee will conduct random weekly audits for three (3) months of call lights to validate that staff response times are appropriate and meet the needs of the residents. Monitoring. The Director of Nursing and/or Designee will bring the results of the audits /observations to the monthly QAPI Committee for three (3) months for review and recommendations.	

Random ~~Audit~~ Direct observation audits will be completed weekly by Director of Nursing or Designee to determine if ADL needs were met in a timely manner as evidenced by grooming, toileting + incontinence needs met. Corrective action will be taken as needed

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F 353	Continued From page 15	F 353	Date of compliance is ~~February~~ 16, 2015 2/23/15	

2/19/15