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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
535024 Y1	A. Building B. Wing Y2	1/15/2016 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0279	Correction	ID Prefix F0431	Correction	ID Prefix F0492	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.75(b)	Completed
LSC	12/27/2015	LSC	12/27/2015	LSC	12/27/2015
ID Prefix F0505	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.75(j)(2)(ii)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/27/2015	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) T.J.	DATE 1/20/16	SIGNATURE OF SURVEYOR	DATE 1/22/16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 01/29/2016
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 ______	R-C 01/15/2016

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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 ADON- Assistant director of nursing CAA- Care area assessment CNA- Certified nurse aide DON- Director of nursing services MAR- Medication administration record MDS- Minimum Data Set LPN- Licensed practical nurse 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. F 281 Services Meet Professional Standards	
{F 281} SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility failed to ensure physician's orders were followed for 4 of 37 sample residents (#20, #25, #52, #88). The findings were: 1. Review of the medical record showed resident #20 required daily medication for Diabetes Mellitus. Review of the January 2016 medication review form showed the physician ordered blood sugar levels before meals and at bedtime and sliding scale insulin based on the results of the blood sugar levels, Lantus insulin 40 units at bedtime, and Metformin 500 mg pills twice daily.	{F 281}	It is the practice of the facility to strive to ensure that services provided or arranged by the facility meet professional standards of quality. Corrective Action Resident #20's physician has reviewed blood sugars and insulin orders. Wound treatment orders for #52 were reviewed and updated. Resident #25's physician reviewed resident's antihypertensive orders and blood pressure results and blood pressure parameters were discontinued on 2.3.16 Resident #88's physician has reviewed blood sugar results and insulin orders.	2/23/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Admin | (X6) DATE 2/8/16

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.

RECEIVED
FEB 08 2016
Healthcare Licensing and Surveys

POC accepted. Call to Tony [illegible], NHA on 2/17/16 @ 11:36 am -

~~Additional change on pg. 68/71 for POC. Tony called on 2/19/16~~ [illegible] error RR

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{F 281}	Continued From page 1 Further review of the medication review form showed the parameters for the sliding scale insulin administration addressed blood sugar levels up to 350 (this number is milligrams of glucose per deciliter of blood), but failed to address blood sugar levels above 350. The following concerns were identified: a. Review of the January 2016 MAR showed the resident did not receive the sliding scale insulin dose and/or staff did not check the resident's glucose level at various times from 1/4/16 to 1/9/16 because s/he refused. b. Review of the nursing progress notes and documented communication with the physician showed staff did not report their inability to obtain the blood sugar levels as ordered, elevated blood sugar levels above 350, and omitted insulin doses to the physician. c. Interview with the ADON on 1/14/16 at 8:45 AM revealed staff should have reported the elevated blood sugar levels and lack of insulin administration to the physician. He further stated the physician's order for sliding scale insulin was unclear regarding levels above 350, and the nurses should have clarified the order. 2. Review of the December 2015 and January 2016 MARs showed resident #25 had orders related to his/her diagnosis of hypertension. These orders were dated 11/10/15 and included "Lisinopril Tablet 2.5 mg, 1 tablet daily in the morning. Hold if systolic blood pressure (BP) less than 100" and "Metoprolol tartrate tablet 25 mg, give 0.5 tablet by mouth 2 times per day. Hold if systolic BP less than 110 or heart rate less than 60." Further review of the MARs showed the resident received these medications daily except on 1/3/16 when both medications were shown to be held due to the resident being hospitalized.	{F 281}	**Identification of Others** An audit has been completed by Director of Nursing / designee, to identify any residents that are diabetic and have finger stick blood sugar orders and / or insulin orders. The audit includes checking for parameters for physician notification of blood sugar results and notification of physician of results outside of the parameters and correct administration of insulin per orders. Corrective actions will be taken as needed. An audit will be completed by Director of Nursing or designee of medication and treatment administration records for the past 2 weeks to identify any instances where medication or treatment was not provided due to pattern of resident refusal or supplies not being available. The audit will also include checking that vital signs completed as needed and any additional parameters for medication administration are followed. Corrective actions will be taken as needed including physician notification. **Systemic Changes** The Director of Nursing or designee will educate the licensed nursing staff, on or before date of compliance, regarding the notification of the physician and	

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{F 281}	Continued From page 2 Also on 1/2/16, 1/8/16, and 1/9/16 the 9 PM dose of Metoprolol was held "due to condition." The following concerns were identified: a. Review of the MARs and the medical record failed to show the BP or heart rate were taken prior to the medications being administered. In addition, the progress notes failed to show the resident was out of the facility on 1/3/16, or why the medication was held on the other dates. b. Review of the vital sign documentation in the chart showed in December 2015 the resident's heart rate was taken only 18 times with no values less than 60. On 1/13/16 the January vital signs for heart rate were reviewed, and there were only two times when these values were recorded with none below 60. c. Review of the December 2015 BP documentation showed only 18 times when the values were recorded. On 12/10/15 at 6:51 PM the value was 89/60, and the metoprolol was administered at 9 PM according to the MAR. d. Review of the January 2016 documentation for BP showed only 5 times when the value was recorded. e. Interview with the DON on 1/15/16 at 5:30 PM verified she was unable to find any additional documentation of vital signs and confirmed they should be taken prior to administration of these medications. 3. Review of the 11/12/15 quarterly MDS assessment showed resident #88 had diagnoses that included diabetes. Review of the physician orders showed the resident was to receive 5 units of NovoLog insulin before meals, with the medication to be held if the resident's blood sugar was below 150. Review of the January 2016 MAR revealed the following concerns:	{F 281}	resident's legal representative any acute changes in condition and noting this notification in the medical record. The education will include physician notification of patterns of refusals of medication or treatment, physician notification when supplies or medications are not available and obtaining alternative orders until supplies or medications are available and following parameters on physician orders and obtaining vital signs as needed.. The education will also include obtaining parameters for physician notification of finger stick blood sugar results, notification of physician when blood sugar results are outside of the parameters, and following physician orders for insulin. The Director of Nursing or designee will audit finger stick blood sugar orders and results and insulin administration weekly for 1 month for correct administration and physician notification of results outside of parameters. After 1 month, random audit of 3-5 finger stick blood sugar results and follow up will be completed weekly for 2 months. Corrective actions will be taken as needed based on findings.	

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(F 281)	Continued From page 3 a. There was no evidence the resident's blood sugar was checked or the insulin administered prior to 10 meals between 1/1/16 and 1/14/16. b. The resident was administered insulin on 3 occasions when the blood sugar was indicated to be below the specified parameter of 150. c. The resident was administered insulin 11 times with no documented blood sugar. d. Interview with the DON, ADON, and corporate RN on 1/15/16 at 2:15 PM confirmed the MAR indicated the resident received insulin when the blood sugar was below the specific parameter. Interview with the DON on 1/15/16 at 8 PM revealed there was no additional documentation to provide related to the resident's insulin administration. 4. Review of the 11/12/15 admission MDS assessment showed resident #52 was admitted with a surgical wound, and was receiving surgical wound care. Further, the resident required the extensive assistance of 2 or more persons for most ADLs. Review of the resident's care plan for skin issues showed an intervention dated 11/16/15, "Observe wound healing and maintain wound vac [vacuum] as dressing..." Review of physician orders showed a 12/24/15 order for "Wound vac to R [right] buttock wound. Wound vac maintenance daily with dressing change on MON [Monday], WED [Wednesday] and FRI [Friday] every day and night shift..." The following concerns were identified: a. Review of the 12/27/15 late entry for 12/26/15 progress note showed "...was going to change wound vac to right buttock area, no wound canisters were found..." b. Review of the 12/27/15, timed 6:27 PM, progress noted showed "wound continues to be	(F 281)	The Director of Nursing or designee will complete an audit of medication and treatment records weekly for 1 month and then a random audit of 25% of records weekly for 2 months for patterns of refusals, unavailability of supplies or medications and physician notification and obtaining vital signs as ordered and administering medication per physician orders. Corrective actions will be taken as needed based on findings. **Monitoring** The Director of Nursing will report the findings to the QAPI Committee to evaluate the effectiveness of the systemic changes and implement additional interventions as needed to need for continued monitoring based on compliance until resolved.	

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{F 281}	Continued From page 4 without wound vac..." c. Further review of the medical record showed the order for the wound vac was not discontinued until 12/30/15. d. Interview with the DON, ADON and corporate RN on 1/15/16 beginning at 2:05 PM confirmed the resident's wound vac was not changed according to the physician's orders because the facility did not have the needed supplies. Further, the DON confirmed the physician was not contacted regarding the facility's inability to apply the wound vac until 12/30/15.	{F 281}		
{F 309} SS=G	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 adequate care and/or timely response to a change of condition for 5 of 35 sample residents (#20, #25, #52, #88, #116). This failure resulted in actual harm for 2 residents (#20, #116) who were transported to the hospital for acute care. The findings were: 1. Review of the 5/12/15 interdisciplinary team note showed resident #116 was admitted to the	{F 309}	**F-309: Provide Care/Services for Highest Well Being** It is the practice of the facility to strive to ensure that each resident receives the necessary care and services to attain or maintain the highest practicable physical or mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. **Corrective Action** Resident #116 no longer resides at the facility. Resident #20's physician has reviewed resident's blood sugars and insulin orders.	2/23/16

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(F 309)	Continued From page 5 facility for rehabilitation after lumbar surgery, and infection of the surgical wound. The following concerns were identified: a. Review of the nursing note dated 5/27/15 and untimed showed "Resident crying out this am, very drowsy from pain meds [medications] earlier & flexeril [a muscle relaxant], c/o [complains of] that [s/he] couldn't feel [his/her] legs, difficulty sitting up @ [at] bedside, very adamant that [s/he] wanted to lay in bed..." b. Review of the 5/28/15, untimed, late entry for 5/27/15 nursing note showed "Request to get resident in to see [physician name] @ [clinic name] d/t [due to] increased pain and difficulty moving [his/her] legs. [S/he] was rescheduled with an appt. [appointment] for 29th. Incision noted to be without s/sx [signs/symptoms] infection and resident was ext X 1 asst [extensive assist of 1 person] with transfer to recliner with nurse." c. Further review of the medical record showed no evidence the physician was contacted directly about the resident's increased pain and inability to feel his/her legs. d. Review of the 5/29/15 nurse's note timed at 11:50 PM indicated the resident had an appointment at the clinic, and returned with new orders. Notes from this appointment were requested from the facility, and were not available. e. Review of the 5/31/15 "SBAR Communication Form and Progress Note" timed at 9 PM showed "Increased lumbar pain unrelieved by medications, no feeling in either leg. Demands to go to [clinic name] for eval [evaluation] by [his/her] surgeon [physician name]..." The note further showed the resident was transferred to the hospital via non-emergent ambulance, and subsequently taken to a Denver,	(F 309)	Wound treatment orders have been reviewed and updated for resident #52. The physician reviewed resident #25's antihypertensive orders and blood pressure results and blood pressure parameters were discontinued. The physician has reviewed #88's blood sugar results and insulin orders. **Identification of Others** An audit will be completed by Director of Nursing / designee, to identify any residents with an acute change of condition within the last 30 days to ensure that the resident's physician and legal representative was notified of the change, orders obtained and written as needed and care plan updated when needed. Corrective actions will be taken as needed. An audit has been completed by Director of Nursing / designee, to identify any residents that are diabetic and have finger stick blood sugar orders and / or insulin orders. The audit includes checking for parameters for physician notification of blood sugar results and notification of physician of results outside of the parameters and correct administration of insulin per orders.	

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(F 309)	Continued From page 6 Colorado hospital via emergency air transport. f. Review of the 6/1/15, untimed, nurse's note showed the resident was sent to a Denver hospital related to "L4 & L5 (lumbar vertebrae) disintegrating due to infection." g. Interview with the DON, ADON and corporate nurse on 1/15/16 beginning at 2:05 PM confirmed the facility could provide no evidence the resident's physician was consulted about the change in condition on 5/27/15. 2. Review of the medical record showed resident #20 required daily medication for Diabetes Mellitus. Review of the January 2016 medication review form showed the physician ordered blood sugar levels before meals and at bedtime and sliding scale insulin based on the results of the blood sugar levels, Lantus insulin 40 units at bedtime, and Metformin 500 mg pills twice daily. Further review of the medication review form showed the parameters for the sliding scale insulin administration addressed blood sugar levels up to 350 (this number is milligrams of glucose per deciliter of blood), but failed to address blood sugar levels above 350. The following concerns were identified: a. Review of the January 2016 MAR showed the resident did not receive the sliding scale insulin dose and/or staff did not check the resident's glucose level at various times from 1/4/16 to 1/9/16 because s/he refused. This review showed the resident did not receive the sliding scale insulin for the following documented blood sugar levels: 464 at 1 PM and 387 at 9 PM on 1/4/16; 572 at 1 PM and 472 at 5 PM on 1/5/16; 486 at 1 PM on 1/6/16; 499 at 5 PM on 1/7/16; and 499 at 9 AM on 1/8/16. b. Review of the nursing progress notes and documented communication with the physician	(F 309)	Corrective actions will be taken as needed. An audit will be completed by Director of Nursing or designee of medication and treatment administration records for the past 2 weeks to identify any instances where medication or treatment was not provided due to pattern of resident refusal or supplies not being available. The audit will also include checking that vital signs completed as needed and any additional parameters for medication administration are followed. Corrective actions will be taken as needed including physician notification. Systemic Changes The DON or designee will educate the licensed nursing staff, on or before date of compliance, regarding the notification of the physician and resident's legal representative any acute changes in condition and noting this notification in the medical record. The education will include physician notification of patterns of refusals of medication or treatment, physician notification when supplies or medications are not available and obtaining alternative orders until supplies or medications are available and following parameters on physician	

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{F 309}	Continued From page 7 showed staff did not report their inability to obtain the blood sugar levels as ordered, the elevated blood sugar levels, and omitted insulin doses to the physician. c. Interview with the DON on 1/11/16 at 2:05 PM revealed the resident was transported to the hospital on 1/10/16 and his/her blood sugar level was 600. Interview with the ADON on 1/14/16 at 8:45 AM revealed staff should have reported the elevated blood sugar levels and lack of insulin administration to the physician. He further stated the physician's order for sliding scale insulin was unclear regarding levels above 350, and the nurses should have clarified the order. 3. Review of the 11/12/15 admission MDS assessment showed resident #52 was admitted with a surgical wound, and was receiving surgical wound care. Further, the resident required the extensive assistance of 2 or more persons for most ADLs. Review of the resident's care plan for skin issues showed an intervention dated 11/16/15, "Observe wound healing and maintain wound vac [vacuum] as dressing..." Review of physician orders showed a 12/24/15 order for "Wound vac to R [right] buttock wound. Wound vac maintenance daily with dressing change on MON [Monday], WED [Wednesday] and FRI [Friday] every day and night shift..." The following concerns were identified: a. Review of the 12/27/15 late entry for 12/26/15 progress note showed "...was going to change wound vac to right buttock area, no wound canisters were found..." b. Review of the 12/27/15, timed 6:27 PM, progress noted showed "wound continues to be without wound vac..." c. Further review of the medical record showed the order for the wound vac was not	{F 309}	orders and obtaining vital signs as needed.. The education will also include obtaining parameters for physician notification of finger stick blood sugar results, notification of physician when blood sugar results are outside of the parameters, and following physician orders for insulin. The Director of Nursing or designee will review incident / accident reports, 24 hour report and the clinical dashboard in Point Click Care in morning meeting daily Monday or Friday to identify any resident change of condition. Documentation will be reviewed for physician notification for identified change of condition. The Director of Nursing or designee will review Change of Conditions daily Monday – Friday for 2 weeks and then review 5 Change of Conditions weekly for 2 months to check that physician and resident's legal representative member was notified of change. The audit will also will also include documentation, review of new orders, appropriate interventions, and care plan. If concerns are identified corrective action will be taken based on findings.	

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{F 309}	Continued From page 8 discontinued until 12/30/15. d. Interview with the DON, ADON and corporate RN on 1/15/16 beginning at 2:05 PM confirmed the resident's wound vac was not changed according to the physician's orders because the facility did not have the needed supplies. Further, the DON confirmed the physician was not contacted regarding the facility's inability to apply the wound vac until 12/30/15. 4. Review of the December 2015 and January 2016 MARs showed resident #25 had orders related to his/her diagnosis of hypertension. These orders were dated 11/10/16 included "Lisinopril Tablet 2.5 mg, 1 tablet daily in the morning. Hold if systolic blood pressure (BP) less than 100" and "Metoprolol tartrate tablet 25 mg, give 0.5 tablet by mouth 2 times per day. Hold if systolic BP less than 110 or heart rate less than 60." Further review of these MARs showed the resident received these medications daily except on 1/3/16 when both medications were shown to be held due to the resident being hospitalized. Also on 1/2/16, 1/8/16, and 1/9/16 the 9 PM dose of Metoprolol was held "due to condition." The following concerns were identified: a. Review of the MARs and the medical record failed to show the BP or heart rate were taken prior to the medications being administered. In addition, the progress notes failed to show the resident was out of the facility on 1/3/16, or why the medication was held on the other dates. b. Review of the vital sign documentation in the chart showed in December 2015 the resident's heart rate was taken only 18 times with no values less than 60. On 1/13/16 the January vital signs for heart rate were reviewed, and there	{F 309}	The Director of Nursing or designee will audit finger stick blood sugar orders and results and insulin administration weekly for 1 month for correct administration and physician notification of results outside of parameters. After 1 month, random audit of 3-5 finger stick blood sugar results and follow up will be completed weekly for 2 months. Corrective actions will be taken as needed based on findings. The Director of Nursing or designee will complete an audit of medication and treatment records weekly for 1 month and then a random audit of 25% of records weekly for 2 months for patterns of refusals, unavailability of supplies or medications and physician notification and obtaining vital signs as ordered and administering medication per physician orders. Corrective actions will be taken as needed based on findings. **Monitoring** The Director of Nursing will report the findings to the QAPI Committee to evaluate the effectiveness of the systemic changes and implement additional interventions as needed to ensure compliance and then reassess the need for continued monitoring based on compliance until resolved.	

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FORM APPROVED
OMB NO. 0938-0391

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	535024	A. BUILDING _____ B. WING _____	R-C 01/15/2016

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(F 309)	Continued From page 9 were only two times when these values were recorded, with none below 60. c. Review of the December 2015 BP documentation showed only 18 times when the values were recorded. On 12/10/15 at 6:51 PM the value was 89/60, and the metoprolol was administered at 9 PM according to the MAR. d. Review of the January 2016 documentation for BP showed only 5 times when the value was recorded. e. Interview with the DON on 1/15/16 at 5:30 PM verified she was unable to find any additional documentation of vital signs and confirmed they should be taken prior to administration of these medications. 5. Review of the 11/12/15 quarterly MDS assessment showed resident #88 had diagnoses that included diabetes. Review of the physician orders showed the resident was to receive 5 units of NovoLog insulin before meals, with the medication to be held if the resident's blood sugar was below 150. Review of the January 2016 MAR revealed the following concerns: a. There was no evidence the resident's blood sugar was checked or the insulin administered prior to 10 meals between 1/1/16 and 1/14/16. b. The resident was administered insulin on 3 occasions when the blood sugar was indicated to be below the specified parameter of 150. c. The resident was administered insulin 11 times with no documented blood sugar. d. Interview with the DON, ADON, and corporate RN on 1/15/16 at 2:15 PM confirmed the MAR indicated the resident received insulin when the blood sugar was below the specific parameter. Interview with the DON on 1/15/16 at 8 PM revealed there was no additional	(F 309)		

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{F 309}	Continued From page 10 documentation to provide related to the resident's insulin administration.	{F 309}	**F315 No Catheter, Prevent UTI, Restore Bladder**	2/23/16
{F 315} SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure toileting was provided in a timely manner for 2 of 9 residents (#77, #108) who required assistance to restore as much normal bladder function as possible. The findings were: 1. Review of the 12/28/15 care plan revealed resident #108 required staff assistance with toileting and incontinence care due to dementia and inability to transfer without staff assistance. According to the care plan, revised 12/18/15, staff were directed to offer assistance and "toilet" upon rising, before and after meals, at bedtime, and as needed. Observation on 1/12/16 at 6:50 AM revealed CNAs #3 and #4 provided urine and fecal incontinent care for the resident before they wheeled him/her to breakfast. Continued observation revealed the resident sat in the	{F 315}	It is the practice of the facility to ensure that based on the comprehensive assessment that a resident that enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. **Corrective Action** Resident #108 will have a 3 day voiding pattern completed to re-establish voiding pattern. After completion of voiding pattern a new bladder evaluation will be completed and care plan updated with new interventions for incontinence management by the Director of Nursing or designee. Care plan and CNA assignment sheet will be updated as necessary to reflect changes. Resident #77 will have a 3 day voiding pattern completed to re-establish voiding pattern. After completion of voiding pattern a new bladder evaluation will be	

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{F 315}	Continued From page 11 hallway and activity room after eating breakfast. At 10:30 AM, after painting the resident's fingernails, the activity staff positioned the resident in front of the television. At that time the resident had a fecal odor. The resident remained in that position until 11:50 AM when bath aides #1 and #2 wheeled the resident to the shower room and removed the urine and feces-soiled disposable brief. Interview on 1/15/16 at 11 AM with CNA #4 revealed sometimes staff did not toilet the resident before and after meals because the resident refused. However, the continued observation from 6:50 AM to 11:50 AM revealed staff did not offer the resident toileting assistance. 2. Review of the 1/5/16 care plan showed resident #77 had bladder incontinence related to chronic kidney disease, type 2 diabetes mellitus, weakness, and decreased mobility. Review of the interventions for this problem area showed the resident should be checked upon rising, before and after meals, at bedtime, and as needed. Observation on 1/14/16 at 8:40 AM showed the resident was up to the table for breakfast. The resident was provided intermittent cueing to continue eating as s/he would doze off. At 9:05 AM the resident was taken from the dining room to the activity that was going on in the activity room. Continuous observation showed the resident remained in the activity room sleeping in his/her wheelchair until 10:40 AM when s/he self-propelled out into the 200 unit hallway. At 10:42 AM CNA #8 brought the resident back into the activity. The resident promptly left the room again self-propelling in the wheelchair. The resident was provided a snack in the activity room where s/he remained until 11:45 AM when CNA #7 was preparing to take the resident into the dining room for lunch. At that time the surveyor	{F 315}	completed and care plan updated with new interventions for incontinence management by the Director of Nursing or designee. Care plan and CNA assignment sheet will be updated as necessary to reflect changes. **Identification of Others** The Director of Nursing or designee will identify residents who are incontinent of bladder. The incontinence care plans for those identified will be reviewed and updated as needed. CNA assignment sheets will be reviewed for incontinence interventions and updated as needed. **Systemic Changes** The Director of Nursing or designee will educate nursing staff on timely assistance with toileting and incontinence management per care plan. The Director of Nursing or designee will complete visual observation audits of incontinence 3 times weekly on a random sample of 10 residents for one month and then monthly for two months. The audit will include monitoring for timely assistance to bathroom and incontinence and provision incontinence interventions per care plan. Corrective action will be taken as appropriate for any concerns identified.	

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{F 315}	Continued From page 12 requested the resident be checked for incontinence. At 11:60 AM CNA #1 and LPN #1 transferred the resident to the toilet and according to the LPN the resident's incontinence brief was wet.	{F 315}	**Monitoring** The Director of Nursing will report the findings to the QAPI Committee to evaluate the effectiveness of the systemic changes and implement additional interventions as needed to ensure compliance and then reassess the need for continued monitoring based on compliance until resolved. **F-356: Posted Nurse Staffing Information.** **Corrective Action:** The Federal Staffing Sheet has been revised to accurately reflect CNA hours worked by adding a separate line for NA's and is located in a prominent place which accessible to residents and visitors.. **Identification of Others:** There are no other residents who are affected by this. **Systemic Changes:** The Scheduler has been educated on F-356 and its specific requirements for posting the Federal Staffing Hours.	2/23/16
{F 356} SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	{F 356}		

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(F 356)	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of daily nurse staffing sheets, the facility failed to ensure the posted nurse staffing sheets met the requirements for 20 of 20 days reviewed (12/27/15-1/15/16). The findings were: Observation on 1/15/16 at 9:05 AM revealed the posted daily nurse staffing sheets were not located in a readily accessible place. The posting was placed in a plastic holder which was attached to the wall near the chart room. The posting was high enough on the wall a resident in a wheelchair would not be able to see it or reach it. In addition, review of the daily sheets from 12/27/15 to 1/15/16 showed the information failed to separate the Certified Nurse Aides from non-certified aides. Interview with the administrator, unit assistant, and LPN #1 on 1/15/16 at 9:38 AM revealed they were not aware of the posting placement/accessibility requirement and that the number of and the actual hours worked needed to be listed specifically for CNAs.	(F 356)	The Administrator and/or designee will check for compliance weekly. Non-compliance will be corrected timely. **Monitoring:** The QAPI Committee will evaluate effectiveness of the systemic changes based on additional interventions as needed to ensure compliance then reassess the need for continued monitoring based on compliance until resolved.	